

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) MARGARET T. BAIN						2a. DATE OF DEATH Month June Day 5 Year 1968			2b. HOUR 1:25 MA			
3. SEX Female		4. RACE White		5. DATE OF BIRTH October 6, 1907			6. AGE (In years lost birthday) 60 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Kessamine Co. Ky.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.						
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House wife			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna 908 Eastland Rd.			13b. COUNTY Franklin		13c. CITY OR TOWN Waynesboro, Pa.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 908 Eastland Rd.			
14. FATHER'S NAME First Oliver Middle F. Last Troutman			15. MOTHER'S MAIDEN NAME First Amanda Middle F. Last Goode									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 257-07-0304		17. INFORMANT Address Pa. Warren L. Bain Jr. 908 Eastland Rd. Waynesboro							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5901 endotoxic shock DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) acute left pyelonephritis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours 48 hours		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 600.0 diabetes mellitus, urethral stricture												
19a. DATE OF OPERATION none		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? autopsy not completed					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from May 28, 1968 , to June 4, 1968 , that (I) (we) last saw the deceased alive on June 4, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Joseph C. Crisp M.D.						DEGREE M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-5-68				
22d. PHYSICIAN'S NAME (Type) Joseph C. Crisp, M.D.						22e. ADDRESS Hagerstown Ind.						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/10/1968		23c. NAME OF CEMETERY OR CREMATORY Lexington Cemetery		23d. LOCATION (City or Town) (County) (State) Lexington Jefferson Co. Ky.						
24. FUNERAL DIRECTOR Walter G. Grove				ADDRESS Waynesboro, Penna.		25a. REC'D BY REGISTRAR JUN 7 1968		25b. REGISTRAR'S SIGNATURE William J. Young				

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09053

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09063

1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			Month Day Year			2b. HOUR		
HAROLD EDWARD BEAN						June 3 1968			11			M		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD			2d. HOUR			
Male	White	Dec 8 1923	44 YRS.					June 3 1968			11a M			
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>			9. COUNTY OF DEATH			Md.		
Maryland			U.S.A.			Washington								
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY					
Hagerstown			Wash County Hospital			Taxi Driver			Star Cab Co					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. CITY OR TOWN			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER					
Maryland			Washington Hagerstown						622 W. Washington St					
14. FATHER'S NAME			First Middle Last			15. MOTHER'S MAIDEN NAME			First Middle Last					
Archie S. Bean Sr						Susan E. Kretzer								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS					
No			217-12-2199			Mrs Susan E. Bean			431 W. Church St					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY:												sudden		
IMMEDIATE CAUSE (a) 4109 Coronary occlusion														
DUE TO, OR AS A CONSEQUENCE OF												yrs.		
Atherosclerotic coronary artery disease														
DUE TO, OR AS A CONSEQUENCE OF														
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)														
4201														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?			YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>														
ACTUAL SIGNATURE			M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED					
EXAMINER'S NAME (Type)			Howard N. Weeks, M.D.			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			6/4/68					
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)					
Burial			6/8/68			Rose Hill Cemetery			Hagerstown Wash Co Md.					
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE					
Andrew K. Coffman			Funeral Home Inc			DATE JUN 7 1968								

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WILKINSON, EDWARD, JR. (MAY 1910 - 1970)

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Washington Hamletown

Susan E. Webster

Archie E. Bean Sr

217-12-119

Mrs Susan E. Bean 431 W. Church St

217-12-119

no

Hamletown

Wash Co No.

Hamletown

Hill Cemetery

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Burial

Andrew A. Collins Funeral Home Inc

Hamletown No.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First HARVEY			Middle MICKLEY			Last BELL			2a. DATE OF DEATH Month 6 Day 11 Year 68			2b. HOUR 10 P.M.		
3. SEX Male			4. RACE White			5. DATE OF BIRTH January 9, 1886			6. AGE (In years lost birthday) 82 YRS.			IF UNDER 1 YEAR MONTHS 5 DAYS 1			IF UNDER 24 HRS. HOURS 5 MIN.		
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington Md.								
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Store			12b. KIND OF BUSINESS OR INDUSTRY Grocery								
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland			13b. COUNTY Washington			13c. CITY OR TOWN Williamsport			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET AND NUMBER 128 Bower Ave.					
14. FATHER'S NAME First William H.			Middle Bell			Last 			15. MOTHER'S MAIDEN NAME First Sarah			Middle Hoffman			Last 		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			(If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 220-09-7863			17. INFORMANT Mrs. Ora A. Bell Address 128 Bower Ave. Williamsport, Md.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4109 left coronary artery with propagation into												several days					
DUE TO, OR AS A CONSEQUENCE OF anterior descending branch.																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerosis of aorta and coronary arteries,												several years					
DUE TO, OR AS A CONSEQUENCE OF moderately advanced.																	
Myocardial infarction, probably early, 1st ventricle,																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4201																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 6/6/68 , 19 68 , to 6/11/68 , 19 68 , that (I) (we) last saw the deceased alive on 6/11/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE E. W. Ditto, Jr.			DEGREE			ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			22c. DATE SIGNED 6/13/68								
22d. PHYSICIAN'S NAME (Type) E. W. Ditto, Jr., M.D.			22e. ADDRESS 215 W. Washington St., Hagerstown, Md.														
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE June 14, '68			23c. NAME OF CEMETERY OR CREMATORY Greenlawn Cemetery			23d. LOCATION (City or Town) (County) (State) Williamsport, Wash. Md.								
24. FUNERAL DIRECTOR Albert L. Leaf			ADDRESS 2110 Lex. Ave. Hagerstown, Maryland			25a. REC'D BY REGISTRAR DATE JUN 17 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09060

09065

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) First Middle Last AGNES MAY BENDER			2a. DATE OF DEATH Month Day Year June 20, 1968		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH May 26, 1885		6. AGE (In years last birthday) 83 YRS.	IF UNDER 1 YEAR MONTHS DAYS 3 24
7a. BIRTHPLACE (State or foreign country) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH Washington Md.		
10. CITY OR TOWN OF DEATH Sharpsburg	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Chaplin Street		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife	12b. KIND OF BUSINESS OR INDUSTRY At Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland	13b. COUNTY Washington	13c. CITY OR TOWN Sharpsburg	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER West Chaplin Street	
14. FATHER'S NAME First Middle Last William Henry Stull		15. MOTHER'S MAIDEN NAME First Middle Last Emma Kate Kidwell			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO. 220-54-4735	17. INFORMANT Miss Betsy Bender Sharpsburg, Maryland		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH CAUSED BY: IMMEDIATE CAUSE (a) Coronary Insufficiency 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary sclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized arteriosclerosis					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo. 3+ years 3+ years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from Oct 1967 , to June 20, 1968 , that (I) (we) last saw the deceased alive on June 20, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Halvard Wanger		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22c. DATE SIGNED 6/20/68
22d. PHYSICIAN'S NAME (Type) Halvard Wanger M.D.		22e. ADDRESS Shepherdstown, W. Va.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial	23b. DATE June 23, 1968	23c. NAME OF CEMETERY OR CREMATORY Mt. View Cemetery		23d. LOCATION (City or Town) (County) (State) Sharpsburg, Washington, Md.	
24. FUNERAL DIRECTOR Albert L. Leaf Williamsport, Maryland.		25a. REC'D BY REGISTRAR DATE JUN 24 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

9230

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) First Middle Last Gladys Ruth Bergstresser						2a. DATE OF DEATH Month Day Year June 1, 1968		2b. HOUR 6:40 AM		
3. SEX female		4. RACE white		5. DATE OF BIRTH Nov. 28, 1904		6. AGE (In years last birthday) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) none		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.			13b. COUNTY Fulton Co.		13c. CITY OR TOWN Waterfall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last William G. Bergstresser				15. MOTHER'S MAIDEN NAME First Middle Last Josephine Bergstresser						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no			16b. SOCIAL SECURITY NO. 174-20-3636		17. INFORMANT Address Paul Bergstresser, Waterfall, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral hemorrhage 431.0 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X Hypertension										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from 5/26 , 19 68 , to 6/1 , 19 68 , that (I) (we) last saw the deceased alive on 5/31/68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Wm. O. Rexrode				DEGREE M. D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/1/68		
22d. PHYSICIAN'S NAME (Type) William O. Rexrode M. D.				22e. ADDRESS 145 South Prospect Street						
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-4-68		23c. NAME OF CEMETERY OR CREMATORY Bethel Cemetery		23d. LOCATION (City or Town) (County) (State) Wells Township, Ful. Co. Pa.				
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUN 4 1968		25b. REGISTRAR'S SIGNATURE Charles J. Jones				

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Yulston Co. Station

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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VR A15 (4)
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission). a. STATE <u>Penna.</u> b. COUNTY <u>Franklin</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hagerstown</u>		c. LENGTH OF STAY IN 1b <u>1 DAY</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>State Line</u>		d. STREET ADDRESS <u>State Line</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. Co. Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MASON C. BINKLEY</u>		4. DATE OF DEATH <u>June 24 1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/26/1901</u>
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during prior 12 working mths. or, if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
<u>Retired PostMASTER</u>		<u>State Line, PA.</u>	
11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Charles N. Binkley</u>		14. MOTHER'S MAIDEN NAME <u>Mollie Brumbaugh</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes or No, if unknown) <u>no</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>185-01-2382</u>	
17. INFORMANT <u>Mary Binkley</u>		Address <u>State Line, PA.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary Thrombosis</u> DUE TO (c) <u>Arteriosclerotic Heart Disease</u>		INTERVAL BETWEEN ONSET AND DEATH <u>36 hrs.</u> <u>36 hrs.</u> <u>?</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>June 23</u> , 19 <u>68</u> , to <u>June 24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 24</u> 19 <u>68</u> , and that death occurred at <u>1 P.</u> M., from causes and on the date stated above.			
22a. SIGNATURE <u>Lloyd A. Hoffman</u> M.D.		22b. DATE SIGNED <u>6/25/68</u>	
22c. PHYSICIAN'S NAME (Type) <u>Lloyd A. Hoffman</u>		22d. ADDRESS <u>214 N. Pot. St. Hagerstown, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>6/27/68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Reformed Cem.</u>	23d. LOCATION (City or town) (County) (State) <u>State Line, PA.</u>
24. FUNERAL DIRECTOR <u>A. G. Munnich - Greencastle, Pa.</u>		25a. REC'D BY REGISTRAR <u>DATE IN 27 1968</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

Washington
Hagerstown
New to Hospital
Reason of Discharge
Admission
Patient's Name
Address
City
State
Zip
Date of Birth
Sex
Race
Religion
Marital Status
Occupation
Education
Previous Illnesses
Allergies
Family History
Social History
Physical Examination
Vital Signs
Laboratory Tests
Immunization Status
Mental Status
Diagnosis
Treatment
Prognosis
Discharge Instructions
Follow-up
Referral
Signature
Date

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-5. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09066 09071											
1. DECEASED-NAME (Type or Print) Harold Wilbur Bloom						2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 6/8/68			2b. HOUR 12:30 M		
3. SEX male		4. RACE white		5. DATE OF BIRTH 10-8-41		6. AGE (in years last birthday) 26 YRS.		IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>		IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	
7a. BIRTHPLACE (State or foreign country) Maryland			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington		
10. CITY OR TOWN OF DEATH Hagerstown				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Paradise Church Rd. Rt. 6				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) clerk typist		12b. KIND OF BUSINESS OR INDUSTRY truck mfg.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) Maryland						13b. CITY OR TOWN Washington Hagerstown		13c. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		13d. STREET AND NUMBER 200 Robinwood Dr.	
14. FATHER'S NAME Wilbur Norman Bloom						15. MOTHER'S MAIDEN NAME Blanche Rebecca Brown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) yes				16b. SOCIAL SECURITY NO. 1-64 8-64		17. INFORMANT Wilbur N. Bloom, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac tamponade DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 966X (b) Penetrating stab wounds of chest DUE TO, OR AS A CONSEQUENCE OF (c) 982X										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Minutes	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 982X				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. 580 Northern Ave.		City or Town Hagerstown		County Washington State Md.	
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Howard N. Weeks, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED 6/10/68			
EXAMINER'S NAME (Type)		580 Northern Ave. Hagerstown, Md.				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>		ADDRESS (Street, City, Town, or County)			
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE 6-11-68		23c. NAME OF CEMETERY OR CREMATORY Smithsburg Cemetery				23d. LOCATION (City or Town) (County) (State) Smithsburg, Md.			
24. FUNERAL DIRECTOR Minnich Funeral Home, Smithsburg, Md.						25a. REC'D BY REGISTRAR JUN 13 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Meda				Belle	Bowers	Month Day Year June 7 1968		8:30 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Female		White		March 20, 1894		74 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Waynesboro, Pa.		USA				Washington Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Hagerstown		Garlock Nursing Home		Housewife		Own Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland		Washington		Hagerstown				629 Hayes Ave.	
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
Joseph					Coffman	Sarah			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown			16b. SOCIAL SECURITY NO.			17. INFORMANT			
No			219-54-1045			Mr. Robt. K. Bowers 21 Cedar Crest Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>Cordis Rupt</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic Heart Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Chronic cystitis</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
4200									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
				7/21/65		6/7/68			
22a. I certify that (I) (this hospital) attended the deceased from 6/6 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE					22c. DATE SIGNED				
Donald E. Martin, M.D.					6/10/68				
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS				
Donald E. Martin, M.D.					363 S. Cleveland Ave., Hagerstown, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		June 11, 1968		Antietam Natl. Cemetery		Sharpsburg-Washington-Md.			
24. FUNERAL DIRECTOR					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Wm. C. Horst					JUN 12 1968		J. Charles Judge		
Rest Haven Funeral Chapel Hagerstown, Md.					DATE				

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

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CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH Month Day Year			2b. HOUR 7.20 PM		
VAL SMITH BRISTOW Sr						June 13 1968					
3. SEX Male		4. RACE White		5. DATE OF BIRTH July 17 1917		6. AGE (In years last birthday) 50 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Baltimore City		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington			Md.		
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Merchant		12b. KIND OF BUSINESS OR INDUSTRY Retired					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1013 Oak Hill Ave			
14. FATHER'S NAME Floyd B Bristow			First	Middle	Last	15. MOTHER'S MAIDEN NAME Madeline Smith			First Middle Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, or, or unknown) No			16b. SOCIAL SECURITY NO. --- 207-01-4009		17. INFORMANT Mrs Martha W. Bristow			Address 1013 Oak Hill Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>337x</u>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>21 May 68</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Hypertensive Cardiovascular Disease - Arteriosclerotic changes</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8 Dec 63</u> , to <u>Date</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>13 June 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Richard T. Binford</u>		22c. DATE SIGNED 14 June 68		22d. PHYSICIAN'S NAME (Type) Richard T. Binford, M. D.		22e. ADDRESS 1135 Potomac Avenue		Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/16/68		23c. NAME OF CEMETERY OR CREMATORY Rest Haven Cemetery		23d. LOCATION (City or Town) (County) (State) Hagerstown Wash Co Md.					
24. FUNERAL DIRECTOR Andrew K. Coffman		Hagerstown Md.		25a. REC'D BY REGISTRAR DATE JUN 20 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>					

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NAME: VAL SMITH BRISTON ST June 11 1938
RACE: White JULY 17 1917
BIRTHPLACE: USA
CITY: Washington
OCCUPATION: Merchant
HOSPITAL: Wash County Hospital
RELIGION: Baptist
FLOYD & RAYSON
207-01-4000 Mrs. Valene M. Briston 1915 Oak Hill Av
Washington D.C.

Andrew J. Colman Funeral Home Inc
Burlington, Vermont
Burlington, Vermont
Burlington, Vermont

FOR STATE HEALTH DEPT.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or Print)		First ANNIE		Middle MARIAH		Last BROWN		2a. DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day Year	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 12/2/1881		6. AGE (In years last birthday) 86 YRS.		2c. DATE PRONOUNCED DEAD Month Day Year	
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON		2d. HOUR 1:00 PM	
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give a street address) WASHINGTON CO. HOSPITAL		12a. USUAL OCCUPATION (Kind of work done during most of last year, or if retired, when if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e. STREET AND NUMBER 714 MARYLAND AVE.	
14. FATHER'S NAME First HENRY		Middle BIXLER		Last SEVILLA		15. MOTHER'S MAIDEN NAME First SEVILLA		Middle GARVICK	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO		16b. SOCIAL SECURITY NO. 220-09-7862		17. INFORMANT MRS. BESSIS V. GARMAN		ADDRESS HAGERSTOWN MD.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Advanced generalized atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sclerosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>25 yrs</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>4200 Fracture lt. femur</u>									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. <u>9:45 AM 6-6 1968</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Fell at Home</u>					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F. No. <u>714 Maryland A.</u>		City or Town <u>Hagerstown</u>		County <u>Wash Md</u>	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE <u>Edward W. Ditto</u>		EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
				22b. DATE SIGNED <u>6-17-68</u>		ADDRESS (Street, city, town, or county) <u>217 W. Wash. St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 6/18/68		23c. NAME OF CEMETERY OR CREMATORY MT. OLIVET CEM.		23d. LOCATION (City or town) (County) (State) HANOVER PENNA.			
24. FUNERAL DIRECTOR <u>W. J. Norment, Hagerstown, Md.</u>				25a. REC'D BY REGISTRAR DATE JUN 20 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

9820

DATE: 10/15/21 TIME: 11:25:11

ASU

**FOR STATE
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH			2b. HOUR		
Larry James Carbaugh						ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 6-6-68 19			2:31 A.M.		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year		2d. HOUR	
male	white	2-23-39	29 YRS.					6 6 1968		2:31 P.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Maryland		USA				Washington					
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
Hagerstown			Wash. Co. Hospital			clerk			auto dealer		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Md.			Washington			Hagerstown				1035 Concord St.	
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
James B. Carbaugh				Charlotte Pangle							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
yes			1936-1938 214-34-7670			Doris W. Carbaugh, Hagerstown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>gun shot wound head</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1-2 hrs.</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>976x</u>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <u>6-6-68</u>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) <u>Self inflicted gunshot wound head</u>					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>Home</u>		21f. LOCATION Street or R.F.D. No. City or Town County State <u>1035 Concord St. Hagerstown Wash Md</u>							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE		Edward W. Ditto, III, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED		6-7-68	
EXAMINER'S NAME (Type)		Edward W. Ditto, III, M.D.				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		ADDRESS (Street, city, town, or county) <u>217 W. Wash. St. Hagerstown, Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
burial		6-8-68		Rose Hill Cemetery		Hagerstown, Md.					
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Minnich Funeral Home, Hagerstown, Md.						DATE JUN 10 1968		Charles Judge			

66070

66075

LARRY JAMES CARPUGH

White 2-27-36

LARRY JAMES CARPUGH

USA

WASH. CO. HOSPITAL

WASH. CO. HOSPITAL

WASH. CO. HOSPITAL

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

WASHINGTON STATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

09063

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09068

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) RUSSELL FRANKLIN CASSELL				2a. DATE OF DEATH 6 Month 24 Day 1968 Year 68		2b. HOUR 4:30 P.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH 2-12-1896		6. AGE (In years last birthday) 72 YRS.	
7a. BIRTHPLACE (State or foreign country) Penna.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.	
10. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington County Hospital		12a. USUAL OCCUPATION (Kind of work done during most of last year, if retired) Police		12b. KIND OF BUSINESS OR INDUSTRY Police	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penna.		13b. COUNTY Franklin		13c. CITY OR TOWN Fayetteville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME John		15. MOTHER'S MAIDEN NAME Emma		16. SOCIAL SECURITY NO. 210-26-6269		17. INFORMANT Billie M. Cassel	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown Yes		16b. SOCIAL SECURITY NO. 210-26-6269		17. INFORMANT Billie M. Cassel		Address Rd 2 Fayetteville, Penna.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pelvic peritonitis 188X DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of urinary bladder DUE TO, OR AS A CONSEQUENCE OF (c) 1870 generalized arteriosclerosis							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 days 1 yr.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 1870 generalized arteriosclerosis							
19a. DATE OF OPERATION 3-20-68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Carcinoma bladder		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from March 20, 1968 to June 24, 1968 , that (I) (we) last saw the deceased alive on June 24 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Joseph C. Crisp MD				DEGREE MD		22c. DATE SIGNED 6-25-68	
22d. PHYSICIAN NAME (Type) JOSEPH C. CRISP				22e. ADDRESS Hagerstown Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6-27-68		23c. NAME OF CEMETERY OR CREMATORY Norland Cemetery		23d. LOCATION (City or Town) (County) (State) Chambersburg Franklin Penna.	
24. FUNERAL DIRECTOR John O. Park				25a. REC'D BY REGISTRAR JUN 28 1968		25b. REGISTRAR'S SIGNATURE Charles Judge	

02002

12-12-1992

Washington

USA

Primo

Route 25

Franklin Fortville

Primo

02002

John

Route 25

X

Franklin Fortville

yes

Washington

Route 25

Franklin Fortville

yes

Route 25

Franklin Fortville

yes

Route 25

Franklin Fortville

yes

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
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09064		MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09069					
1. DECEASED-NAME (Type or print)		First Ethel Rae		Middle Max	Last Clayton		2a. DATE OF DEATH Month June Day 27 , Year 1968		2b. HOUR 12:30 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH May 22, 1904		6. AGE (In years last birthday) 64 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Job, W. Va.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington Md.					
1d. CITY OR TOWN OF DEATH Hagerstown		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) House Wife		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. CITY OR TOWN Washington		13c. CITY OR TOWN Smithsburg,		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER Smithsburg, Rt. 1			
14. FATHER'S NAME First John W. Middle Teter Last 		15. MOTHER'S MAIDEN NAME First Ella F. Middle Lambert Last 									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) no		16b. SOCIAL SECURITY NO. (If give war or dates of service)		17. INFORMANT Address Mr. Royce Clayton, Cumberland, Md. - Son							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of uterus with metastasis 1829 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1980									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 174x											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 4-16 , 19 68 , to June 27 , 19 68 , that (I) (we) last saw the deceased alive on 6-22-68 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Judge		DEGREE MD		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6-28-68	
22d. PHYSICIAN'S NAME (Type) E. R. Scarpelli		22e. ADDRESS 307 W. Preston St., Baltimore, Md.									
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE June 30, 1968		23c. NAME OF CEMETERY OR CREMATORY Zion Memorial Park		23d. LOCATION (City or Town) (County) (State) Cumberland, Allegany, Md.					
24. FUNERAL DIRECTOR James F. Scarpelli, Cumberland, Md.		ADDRESS 		25a. REC'D BY REGISTRAR DATE JUL - 2 1968		25b. REGISTRAR'S SIGNATURE Charles Judge					

1955

1955

June 27, 1955

June

Clayton

Brace

White

Female

X

Washington

Our home

Housewife

Washington Co. Hospital

Admission

x Smithburg, Md.

Washington Smithburg

Admission

1955

1955

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

09065

09870

1. DECEASED-NAME (Type or print) GERTRUDE			First	Middle	Last	2a. DATE OF DEATH Month Day Year June 7 1968			2b. HOUR 6.40			
3. SEX Female		4. RACE White		5. DATE OF BIRTH August 20 1874			6. AGE (in years last birthday) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH Washington					
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fahrney- Keedy Home			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife			12b. KIND OF BUSINESS OR INDUSTRY Own Home				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 1013 Corbett St				
14. FATHER'S NAME Simon Trumppower			First	Middle	Last	15. MOTHER'S MAIDEN NAME Ruanna Repp			First	Middle	Last	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or (unknown) No		(If yes give war or dates of service) ---		16b. SOCIAL SECURITY NO. None		17. INFORMANT Fred M. Cole 8 Marbern Road						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Enter under acute cardiac vascular 4129 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Coronary Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 yrs 10 days		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4221												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from May 5 , 19 68 , to June 7 , 19 68 , that (I) (we) last saw the deceased alive on June 6 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE G. W. Lelan M.D.		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/8/68						
22d. PHYSICIAN'S NAME (Type) G. W. Lelan M.D.		22e. ADDRESS Boonsboro, Md.										
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 6/9/68		23c. NAME OF CEMETERY OR CREMATORY Little Rose Hill Cemetery			23d. LOCATION (City or Town) (County) (State) near Clear Spring Wash Co Md.					
24. FUNERAL DIRECTOR Andrew K. Coffman		Hagerstown, Md. ADDRESS Funeral Home Inc		25a. REC'D BY REGISTRAR JUN 11 1968		25b. REGISTRAR'S SIGNATURE [Signature]						

100-100000

6.00 1968 June 7 1968 COLE-BLICKENSTAFF CERTITUDE

August 20 1971 93 White Female

1971/1972 X USA Maryland

1971/1972 Maryland - Keady Home Maryland - Keady Home

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1971/1972 Maryland - Keady Home Maryland - Keady Home

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print) IRENE B. COLLIER					2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <input type="checkbox"/> Day <input type="checkbox"/> Year 6-14 1968		2b. HOUR 12:15 PM			
3. SEX F	4. RACE W	5. DATE OF BIRTH 5/26/1914	6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/>	IF UNDER 24 HRS. HOURS <input type="checkbox"/> MIN. <input type="checkbox"/>	2c. DATE PRONOUNCED DEAD Month 6 Day 14 Year 1968		2d. HOUR 12:30 PM		
7a. BIRTHPLACE (State or foreign country) Penn.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington				
10. CITY OR TOWN OF DEATH Hagerstown			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Wash. Co. Hospital			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Home		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Penn.			13b. COUNTY Franklin		13c. CITY OR TOWN Greencastle		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER RR # 2	
14. FATHER'S NAME First EVAN Middle Barkholder Last W			15. MOTHER'S MAIDEN NAME First Marietta Middle CATON Last W							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, (a), or (b) or (c)) NO			16b. SOCIAL SECURITY NO. 220-10-3348		17. INFORMANT Harry C. Collier - Greencastle					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Aspiration gastric contents - 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Penetrating gunshot wound head - laceration DUE TO, OR AS A CONSEQUENCE OF (c) Frontal lobe & Subdural Hematoma								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 hrs		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year HOLYDAY 6-13 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Self inflicted gunshot wound to head					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home		21f. LOCATION Street or R.F.D. No. RR # 2 Greencastle		City or Town Franklin		State Pa.		
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE Edward W. Ditto			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED 6-14-68				
EXAMINER'S NAME (Type) DR. EDWARD W. DITTO III			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>							
217 W. WASHINGTON ST., HAG. MD. 21740			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE 6/16/68		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill		23d. LOCATION (City or Town) (County) (State) Greencastle Pa.			
24. FUNERAL DIRECTOR A. E. Minnich - Greencastle Pa.			ADDRESS			25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE Charles J. ...		

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Private B. Collins

10/25/1918

EDWARD W. OTTO III
115 W. WASHINGTON ST., MAC. MO. 21240

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09072

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09077

1. DECEASED-NAME (Type or Print)			First LAWRENCE	Middle GROVE	Last COOLEY	2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH JUNE DAY 30 YEAR 68			2b. HOUR P.
3. SEX MALE	4. RACE WHITE	5. DATE OF BIRTH 1/13/1914	6. AGE (In years last birthday) 54 YRS.	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH July DAY 3 YEAR 19			2d. HOUR 8:40
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON			Md.
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 1325 OUTER DRIVE.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) NIGHT SUPERVISOR AIR FREIGHT			12b. KIND OF BUSINESS OR INDUSTRY CO.
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE MARYLAND			13b. COUNTY WASHINGTON			13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 1325 OUTER DRIVE
14. FATHER'S NAME First JOSEPH			Middle COOLEY	15. MOTHER'S MAIDEN NAME First FANNIE			Middle GROVE	Last GROVE	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO			16b. SOCIAL SECURITY NO. 21407-4642			17. INFORMANT MRS. JEANNETTE COOLEY			ADDRESS P.O. BOX 473 RIDGELEY W. VA.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gunshot Wound Of Head 955X DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Instant	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 976X									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. June 30, 68			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Shot in head with rifle, self inflicted.			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Home			21f. LOCATION Street or R.F.D. No. City or Town County State Outer Drive, Hagerstown, Washington, Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE Dr. E. W. Ditto, Jr.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED July 3, 1968			
EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr.			M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL			23b. DATE 7/5/68			23c. NAME OF CEMETERY OR CREMATORY CEDAR LAWN MEM. GARDENS HAGERSTOWN WASH. MD.			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN, MD.
24. FUNERAL DIRECTOR W. J. Norman, Hagerstown, Md.			ADDRESS			25a. REC'D BY REGISTRAR JUL - 8 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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UNITED STATES DEPARTMENT OF AGRICULTURE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print)			First <i>Clyde</i>	Middle <i>Edwin</i>	Last <i>Cross, Sr.</i>	2a. DATE OF DEATH Month <i>June</i> Day <i>30</i> Year <i>1968</i>			2b. HOUR <i>M</i>
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>March 6, 1909</i>		6. AGE (In years last birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS <i>1</i> DAYS <i>15</i> HOURS <i>15</i> MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Mt. Lena, Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Washington</i> Md.			
10. CITY OR TOWN OF DEATH <i>Hagerstown</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Washington County Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Machinist Helper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Equip. Mfg.</i>			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Washington</i>		13c. CITY OR TOWN <i>Hagerstown</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>114 Buena Vista Ave.</i>	
14. FATHER'S NAME First <i>Cornelius Sylvester</i> Middle <i>Cross</i> Last <i></i>			15. MOTHER'S MAIDEN NAME First <i>Martha</i> Middle <i></i> Last <i>Zahn</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, <i>No</i> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO. <i>213-18-9984</i>		17. INFORMANT Address <i>C.W. Cross 114 Buena Vista Ave. Hagerstown, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial infarction</i> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary artery Dis.</i> 1-2 yrs DUE TO, OR AS A CONSEQUENCE OF (c) <i>Arteriosclerotic Cardio. Dis.</i> 1-2 yrs PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <i>Hypertension</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>20 Nov</i> , 19 <i>65</i> , to <i>date</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>30 June</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Richard T. Binford, M.D.</i>					22c. DATE SIGNED <i>1 July 68</i>				
22d. PHYSICIAN'S NAME (Type) <i>Richard T. Binford, M. D.</i>					22e. ADDRESS <i>1135 Potomac Avenue Hag. Md.</i>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>7/3/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Rest Haven Cemetery</i>		23d. LOCATION (City or Town) (County) (State) <i>Hagerstown-Washington-Md.</i>			
24. FUNERAL DIRECTOR <i>Wm. C. Horst</i> <i>Rest Haven Funeral Chapel Hagerstown, Md.</i>					25a. REC'D BY REGISTRAR DATE <i>JUL - 5 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>		

VR 415 (M)
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Figure 3

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1. The first step is to identify the problem or question that needs to be answered.

TO HOSPITAL BY ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 is retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 7-62

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Washington</u> MARYLAND						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) e. STATE <u>Md.</u> b. COUNTY <u>WASH.</u>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rural-Cearfoss</u>						c. LENGTH OF STAY IN TB <u>Life</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Cearfoss, Maryland</u>						d. STREET ADDRESS <u>Hagerstown-Cearfoss, Md.</u>					
3. NAME OF DECEASED (Type or print) <u>George W. Cunningham</u>						4. DATE OF DEATH <u>June 10 1968</u>					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>2/4/1905</u>		9. AGE (In years last birthday) <u>63</u> yrs.		IF UNDER 1 YEAR Months Days	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Store Owner</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Grocery Retail</u>				11. BIRTHPLACE (County & State, or foreign country) <u>Wash. Co., Md.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>Victor Cunningham</u>						14. MOTHER'S MAIDEN NAME <u>Lulu Smith</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes give war or dates of service)						16. SOCIAL SECURITY NO. <u>214-09-641</u>		17. INFORMANT <u>Lucille Cunningham - Cearfoss, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> 4109 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Atherosclerotic heart disease +</u> (c) <u>Senile / arterio sclerosis</u> DUE TO INTERVAL BETWEEN ONSET AND DEATH <u>20 Hrs</u> <u>10 yrs</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>4201</u>											
22a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)						22b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town)		(County)		(State)	
21. I certify that (I) (his hospital) attended the deceased from <u>Aug 9 1967</u> to <u>June 10 1968</u> , that (I) (we) last saw the deceased alive on <u>May 3 1968</u> , and that death occurred at <u>9:30</u> M, from the causes and on the date stated above.											
22a. SIGNATURE <u>Edward W. Ditto III</u> M.D.						ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED			
22c. PHYSICIAN'S NAME (Type) <u>Edward W. Ditto, III, M.D.</u>						22d. ADDRESS <u>217 W. Washington Street Hagerstown, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>6/12/68</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>				23d. LOCATION (City, town or county) (State) <u>Greencastle Pa.</u>			
24. FUNERAL DIRECTOR'S SIGNATURE <u>C. E. Munch - Greencastle, Pa.</u>						25a. REC'D BY REGISTRAR <u>JUN 13 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				CERTIFICATE OF DEATH			
1. DECEASED-NAME (Type or print) First Middle Last Katherine Dauchey Cunningham				2a. DATE OF DEATH Month Day Year June 13, 1968			
3. SEX female		4. RACE white		5. DATE OF BIRTH March 15, 1886		6. AGE (In years last birthday) 82 YRS.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Washington	
10. CITY OR TOWN OF DEATH Boonsboro		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Fairney-Keedy Mem. Home		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Civil service		12b. KIND OF BUSINESS OR INDUSTRY Fed. Gov.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Washington		13c. CITY OR TOWN Hagerstown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last Eliphalet R. Merry		15. MOTHER'S MAIDEN NAME First Middle Last Lizzie Center		17. INFORMANT Address Mrs. Earl Grove, Hagerstown, Md.			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) no		16b. SOCIAL SECURITY NO. (If yes give war or dates of service)		17. INFORMANT Address Mrs. Earl Grove, Hagerstown, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4109 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) Arteriosclerotic Heart Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from Sept 5, 1951 , to June 13, 1968 , that (I) (we) last saw the deceased alive on June 13, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Carol A. Hoffman				DEGREE MD		22c. DATE SIGNED 6/14/68	
22d. PHYSICIAN'S NAME (Type) 1104 A. Hoffman				22e. ADDRESS 214 N. Potomac St. Hagerstown Md			
23a. BURIAL, CREMATION, REMOVAL (Specify) burial		23b. DATE 6-15-68		23c. NAME OF CEMETERY OR CREMATORY Lewinsville Cemetery		23d. LOCATION (City or Town) (County) (State) Lewinsville, Virginia	
24. FUNERAL DIRECTOR Minnich Funeral Home, Hagerstown, Md.				25a. REC'D BY REGISTRAR DATE JUN 17 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge	

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WASHINGTON

Washington, D.C. June 1, 1968

Female

White

March 15, 1968

India

USA

Washington

Monrovia

Liberty-Need? New Home

Liberty-Need? New Home

Washington

Washington

Washington

Alphabetic A-Z

Liberty Center

Mrs. Earl Grove, Washington, D.C.

6-1-68 Washington Cemetery, Washington, D.C.

6-1-68 Washington, D.C. JUN 17 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										09076		09081	
MEDICAL EXAMINER'S CERTIFICATE OF DEATH													
1. DECEASED-NAME (Type or Print)		First		Middle		Last		2a. DATE KNOWN OF DEATH		2b. HOUR			
CAROL		L. ouise		DE		VORE		ESTIMATED <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR		6 3 68 M			
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD			
F	White	3-9-1940		28 YRS.		MONTHS DAYS		HOURS MIN.		Month 6 Day 3 Year 1968 M			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH							
Robertsdale, Pa.		U S		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Washington				Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Hagerstown		Wash. Co. Hosp.		Housewife									
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER					
Pa.		Cumberland		Shippensburg		NO <input type="checkbox"/>		17 S Earl St					
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last			
James Frank Brown								Annie Hess					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				181-32-3926		Donald C. Devor		Shippensburg, Pa.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Compound fractured skull brain-stem injury</u> Days 816.1 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 823.4													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
		7-50 P.M. 5/28 1968		Passenger in car hitting utility pole.									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION (Street or R.F.D. No. City or Town County State)									
		Street W. King St.		Shippensburg		Frank. Pa.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)		22b. DATE SIGNED									
<i>Howard N. Weeks</i>		Howard N. Weeks		6/3/68									
		Wash. Co.		ADDRESS (Street, city, town, or county)		Hagerstown, Md.							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)							
Burial		6-6-1968		Spring Hill Cemetery		Shippensburg-Cumb. Pa.							
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE							
<i>John Van Noppe</i>		1438 Shippensburg, Pa.		DATE JUN 7 1968		<i>Charles J. Judge</i>							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div>09077</div> <div>MARYLAND STATE DEPARTMENT OF HEALTH</div> <div>DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201</div> <div>CERTIFICATE OF DEATH</div> <div>09082</div>									
1. DECEASED-NAME (Type or print)			First	Middle	Lost	2a. DATE OF DEATH			2b. HOUR
Imogene Mom Dudley						Month Day Year June 24, 1968			3:15 P.M.
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		IF UNDER 1 YEAR	
female	white		7-9-1880			87 YRS.		MONTHS	DAYS
7a. BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
New Jersey			USA					Washington Md.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Wash. County Hospital			Vice President		Printing, Co.	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
Md.			Wash. Hagerstown					13e. STREET AND NUMBER	
								806 Frederick, St.	
14. FATHER'S NAME			First	Middle	Lost	15. MOTHER'S MAIDEN NAME			First Middle Lost
Edward W. Insley									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT			Address
no			219-20-2176			Mr. James I. Dudley			Hagerstown, Md.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>174X</u> Metastatic pulmonary carcinoma									13 yr.
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>Carcinoma of the breast</u>									27 years
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>170X</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Arteriosclerotic heart disease and chronic valvular disease									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <u>June 24</u> , 19 <u>68</u> , to <u>June 24</u> , 19 <u>68</u> , that (I) (we) lost saw the deceased alive on <u>June 24</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>B. B. Kneisley M.D.</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>						22c. DATE SIGNED 6/25/68			
22d. PHYSICIAN'S NAME (Type) B. B. Kneisley, M.D.						22e. ADDRESS 148 West Washington Street Hagerstown, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			6-26-1968		Rest Haven Cemetery		Hagerstown, Md.		
24. FUNERAL DIRECTOR ADDRESS						25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Minnich Funeral Home Hagerstown, Md,						JUN 27 1968		<u>Charles Judge</u>	

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7. *Exposition*

212-37-5175 Mr. J. James I.

K. Volpert

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
09073																	
09083																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First NORA			Middle PEARL		Last EARLEY		2a. DATE OF DEATH JUNE Month 23 Day 1968		2b. HOUR 10:40 AM					
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH 5/22/1881		6. AGE (In years last birthday) 87 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.							
7a. BIRTHPLACE (State or foreign country) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WASHINGTON				Md.							
10. CITY OR TOWN OF DEATH HAGERSTOWN		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 509 FREDERICK ST.		12a. USUAL OCCUPATION (Kind of work done during life, even if retired.) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY HOME											
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) MARYLAND		13b. COUNTY WASHINGTON		13c. CITY OR TOWN HAGERSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 509 FREDERICK ST.									
14. FATHER'S NAME First FRANKLIN			Middle WOLF			Last LAURETTA			15. MOTHER'S MAIDEN NAME First LAURETTA			Middle MARTZ			Last HAGERSTOWN		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 217-32-5686B			17. INFORMANT MR. NORMAN S. EARLEY SR.			Address HAGERSTOWN			MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4450 Gangrene of rt. foot DUE TO, OR AS A CONSEQUENCE OF Peripheral atherosclerotic arterial disease yrs. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) 4501																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from 6/17/68, 19, to 6/23/68, that (I) (we) last saw the deceased alive on June 22, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE H. N. Weeks		DEGREE M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/>		MED. DIRECTOR <input type="checkbox"/>		STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 6/24/68							
22d. PHYSICIAN'S NAME (Type) Howard N. Weeks, M.D.		22e. ADDRESS 580 Northern Avenue, Hagerstown, Md.															
23a. BURIAL, CREMATION, REMOVAL BURIAL		23b. DATE 6/26/68		23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.		23d. LOCATION (City or Town) HAGERSTOWN		(County) WASH.		(State) MD.							
24. FUNERAL DIRECTOR W. J. Norman		ADDRESS Hagerstown, Md.		25a. REC'D BY REGISTRAR DATE JUL - 1 1968		25b. REGISTRAR'S SIGNATURE J. Charles Judge											

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4. THE YOUNG MAN IN THE TOWER

Staphylococcus aureus

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)
30M REV. 1/68

09079		DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201				09084				
1. DECEASED-NAME (Type or print)						2a. DATE OF DEATH		2b. HOUR		
First Middle Last Virgie May Fahrney						Month Day Year June 24, 1968		6:00 PM		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		
Female		White		Feb. 15, 1884		84 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
San Mar, Md.		U. S. A.				Washington Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY	
Hagerstown			Washington Co. Hospital			Homemaker			Own Home	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Maryland			Washington		Boonsboro		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Rfd. 2	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Joseph Fahrney			First Middle Last Jennie Cost							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address					
No.			216-46-4667		Mrs. Mary Fahrney, Rfd. 2, Boonsboro, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) Myocardial Infarction								36 hours		
DUE TO, OR AS A CONSEQUENCE OF										
(b) Anterior wall Heart Disease								several years		
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)										
4201										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
		HOUR A.M. Month Day Year P.M. 19								
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>										
22a. I certify that (I) (this hospital) attended the deceased from Jan 1962, to June 24, 1968, that (I) (we) last saw the deceased alive on June 24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
Edson B. Moody, M.D.							6-27-68			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
					363 S. Cleveland Ave. Hagerstown, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		6-27-68		Mt. Zion Cemetery		San Mar, Wash. Co., Md.				
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.					JUL - 1 1968		Charles Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH																	
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201																	
CERTIFICATE OF DEATH																	
1. DECEASED-NAME (Type or print)			First LAURA			Middle CATHERINE			Last FAUVER			2a. DATE OF DEATH JUNE Month 29 Day 1968			2b. HOUR 8A M		
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH 8/1/1903			6. AGE (In years last birthday) 64 YRS.			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) MARYLAND			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH WASHINGTON Md.								
10. CITY OR TOWN OF DEATH HAGERSTOWN			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 41 E. ANTIETAM ST.			12a. USUAL OCCUPATION (Kind of work done during last year) REGISTERED NURSE			12b. KIND OF BUSINESS OR INDUSTRY HOME								
13a. USUAL RESIDENCE (Where deceased admission) MARYLAND			13b. COUNTY WASHINGTON			13c. CITY OR TOWN HAGERSTOWN			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET AND NUMBER 41 E. ANTIETAM ST.					
14. FATHER'S NAME First JOHN			Middle H.			Last FAUVER			15. MOTHER'S MAIDEN NAME First LAURA			Middle C.			Last BRAKE		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. 213-24-7598			17. INFORMANT MISS ETHEL G. FAUVER			HAGERSTOWN MD.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 4319 IMMEDIATE CAUSE (a) Cerebral Hemorrhage DUE TO, OR AS A CONSEQUENCE OF. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Atherosclerosis, General DUE TO, OR AS A CONSEQUENCE OF (c) Not known APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 Hr.																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 331X																	
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?								
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 1968			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)											
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that (I) (this hospital) attended the deceased from 2/6/68, 1968, to 6/29, 1968, that (I) (we) last saw the deceased alive on 5/20/68, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE A. H. Rieger			22c. DATE SIGNED 6/1/68			DEGREE ATTENDING PHYS. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>											
22d. PHYSICIAN'S NAME (Type) A. H. Rieger			22e. ADDRESS 119 E. Antietam St. Hagerstown														
23a. BURIAL CREMATION, BOTH <input checked="" type="checkbox"/>			23b. DATE 7/2/68			23c. NAME OF CEMETERY OR CREMATORY ROSE HILL CEM.			23d. LOCATION (City or Town) (County) (State) HAGERSTOWN WASH. MD.								
24. FUNERAL DIRECTOR W. J. Norment, Hagerstown, Md.			ADDRESS			25a. REC'D BY REGISTRAR DATE JUL - 3 1968			25b. REGISTRAR'S SIGNATURE Charles Judge								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|---|---|--|---|--|--------------------------------|--|
| 09081 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 09086 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | |
| Eva | | | Ford | | | June 30 1968 | | 8:00AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | Oct. 12, 1877 | | 90 YRS. | | 8 18 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | IF UNDER 24 HRS.
HOURS MIN. | |
| Boonsboro, Md. | | U. S. A. | | | | Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Jackson Convalescent Home | | Housekeeper | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Boonsboro | | | | 24 Potomac St. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| Joshua Ford | | | Mary Brish | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No. | | | 220-30-7612 | | Miss Elizabeth Wheeler, 24 Potomac St. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u>
<u>4409</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>myocardial infarction</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>years</u>
<u>years</u> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>4500</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-10-</u> , 19 <u>65</u> , to <u>6-30-</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June 3</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Joseph Secondari</u> | | 22c. DATE SIGNED
<u>7-1-68</u> | | 22d. PHYSICIAN'S NAME (Type) Joseph Secondari, M.D. | | | | | |
| 22e. ADDRESS
<u>21 N. Main St., Boonsboro, Md.</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 7-2-68 | | Boonsboro Cemetery | | Boonsboro, Wash. Co., Md. | | | |
| 24. FUNERAL DIRECTOR | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | JUL - 5 1968 | | <u>Charles Judge</u> | |

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DATE OF DEATH

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CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|--|---|---|--|---|---|--|--|--|
| 1. DECEASED-NAME
(Type or print)
Charles Wesley Foster | | | 2a. DATE OF DEATH
June Month 9 Day 1968 Year | | | 2b. HOUR
10:58 M | | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
1/17/96 | | 6. AGE (In years last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Ohio | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
restaurant employee | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Frederick | | 13c. CITY OR TOWN
Frederick | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
10004 West 7th St. | |
| 14. FATHER'S NAME
First Francis Middle Foster Last Foster | | | 15. MOTHER'S MAIDEN NAME
First Charlotte Middle Kaderly Last Kaderly | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)
Yes W.W. One | | | 16b. SOCIAL SECURITY NO.
221-07-6626 | | 17. INFORMANT
Address
Mr. Charles W. Foster, Jr. Frederick, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cardiorespiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) Pulmonary Emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
25 yrs | |
| | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
5271 Cardiac Hypertrophy | | | | | | | | | | |
| 19a. DATE OF OPERATION
2/17/68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
Interochanteral Fracture of Right Femur | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, natify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 25, 1968 , to June 9, 1968 , that (I) (we) lost the deceased alive on June 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Dr. U. Porciuncula M.D. | | 22c. DATE SIGNED
June 10, 1968 | | | 22d. PHYSICIAN'S NAME (Type)
Dr. U. Porciuncula, M.D. | | | | | |
| 22e. ADDRESS
Western Md. State Hosp., Hagerstown, Md. | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
6-12-68 | | 23b. DATE
6-12-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Silverbrook | | | 23d. LOCATION (City or Town) (County) (State)
Washington D.C. | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
R. Z. Daily & Son Frederick, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 14 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|----------------------|--|-----------------------------------|--|
| 1. DECEASED-NAME (Type or Print) <i>CATHERINE</i> First Middle Last <i>CANDLER FOX</i> | | | | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <i>6/13/68</i> | | | 2b. HOUR <i>1 AM</i> | | | |
| 3. SEX <i>FEMALE</i> | | 4. RACE <i>WHITE</i> | | 5. DATE OF BIRTH <i>SEPT 26 1902</i> | | 6. AGE (In years last birthday) <i>65</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i> | | | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH <i>WASHINGTON</i> | | | 2d. HOUR <i>2 AM</i> | |
| 10. CITY OR TOWN OF DEATH <i>HAGERSTOWN</i> | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>WASHINGTON COUNTY HOSPITAL</i> | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>HOMEMAKER</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE <i>MARYLAND</i> | | | | 13b. COUNTY <i>WASHINGTON</i> | | 13c. CITY OR TOWN <i>LANTZ</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| 14. FATHER'S NAME First Middle Last <i>CHARLES B CANDLER</i> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last <i>HARRIETTE BUCK</i> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> | | | | 16b. SOCIAL SECURITY NO. (If yes give war or dates of service) | | 17. INFORMANT <i>MRS T P WOODING</i> <i>1124 COSBY STREET LYNCHBURG VIRGINIA</i> | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>4129 congestive failure</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) <i>or Pericard. Condu via dis</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>hrs</i>
<i>yes</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<i>4221</i> | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. <i>19</i> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>H.N. WEEKS</i> | | EXAMINER'S NAME (Type) <i>H.N. WEEKS</i> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED <i>6/15/68</i>
<i>588 Northampton Hagerstown Md</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>REMOVAL</i> | | 23b. DATE <i>6/13/68</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>SPRING HILL CEMETERY</i> | | 23d. LOCATION (City or Town) (County) (State) <i>LYNCHBURG CAMPBELL VA.</i> | | | | | | |
| 24. FUNERAL DIRECTOR <i>Charles S. Rouger</i> | | | | ADDRESS <i>HAGERSTOWN MARYLAND</i> | | 25a. REC'D BY REGISTRAR <i>JUN 18 1968</i> | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|---|---|---|-----------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR |
| CHARLES | | | WALTER | GANO | Month
June | | | Day
30, | Year
1968 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | |
| Male | | White | | Nov. 8, 1910 | | 57 YRS. | | MONTHS
7 | DAYS
22 |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| West Virginia | | USA | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Williamsport | | | Williamsport RFD #2 | | | Laborer | | Tannery | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | RFD #2 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
Charles M. Gano | | | First Middle Last
Ella Barrett | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| No | | | 219-12-1044 | | Williamsport, Maryland
Mrs. Mabel H. Gano RFD #2 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolus</u> | | | | | | | | | 10 minutes |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Cor Pulmonale</u> | | | | | | | | | ?? |
| DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Pulmonary Emphysema and Fibrosis</u> | | | | | | | | | ?? |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 5271 None | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>05/29/68</u> 19__, to <u>06/30/68</u> 19__, that (I) (we) lost the deceased alive on <u>06/18/68</u> 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED |
| Archie Robert Cohen, M.D., | | | | | | | | | 07/04/68 |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | |
| | | | | | Clear Spring, Maryland 21722 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | |
| Burial | | July 3, 1968 | | Cedar Lawn Memorial Park | | Hagerstown, Washington, Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Albert L. Leaf | | | | | Williamsport, Maryland | | JUL - 5 1968 | | Charles Judge |

32000



FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09085

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09090

| | | | | | |
|---|-------------------------|---|---|---|-------------------------------|
| 1. DECEASED-NAME
(Type or Print)
ROGER LEE GIFFIN | | | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 6 15 1968 12:40 PM | | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
Apr. 28, 1946 | 6. AGE (in years last birthday)
22 YRS. | IF UNDER 1 YEAR
MONTHS OAYS | IF UNDER 24 HRS.
HOURS MIN |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH
Dargan (Rural) | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
DOA Washington Co. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Antietam | |
| 14. FATHER'S NAME
Ellsworth Robert Giffin, SR. | | 15. MOTHER'S MAIDEN NAME
Leda Constance Saylor | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
236-72-0663 | | 17. INFORMANT
Mrs. Jo Ann Giffin, Harpers Ferry, W. Va. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Skull Fracture & Massive
819.9
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Brain Stem Injury
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
20 Min | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
825.4 | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
12 PM 6-15 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Auto Accident | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Harpers Ferry, Md | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Neer -> Dargan wash Md | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | |
| ACTUAL SIGNATURE
Edward W. Ditto III | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED
6-15-68 | |
| EXAMINER'S NAME (Type)
EDWARD W. DITTO III | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county)
217 W. WASHINGTON ST, HAG, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6/17/68 | | 23c. NAME OF CEMETERY OR CREMATORY
Boonsboro Cemetery | |
| 24. FUNERAL DIRECTOR
J. Donald Eckles | | ADDRESS
Harpers Ferry, W. Va. 25425 | | 25a. REC'D BY REGISTRAR
DATE JUN 17 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
J. Charles Yager | |
| 23d. LOCATION (City or Town) (County) (State)
Boonsboro, Washington, Md. | | | | | |

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ROGER DEB GIPPIN

Male White Apr. 28, 1943 23

Maryland USA Washington

Debian (Patri) DOA Washington Co. Hosp. Clinician

Maryland Washington American

Elsworth Robert Gillin, Sr. Beda Constance Saylor

230-72-0003 Mrs. 40 Ann Gillin, Harpers Ferry, W. Va.

Skull Fracture & Meningeal
Brain Stem Injury

Mr. & Mrs. R. H. H. H. H. H.

Harpers Ferry Rd West + Barton with

Edward W. Pittman

EDWARD W. PITTMAN III
217 W. WASHINGTON ST. HAZ., MD.

Boonsboro Cemetery Boonsboro, Washington, Md.

Harpers Ferry, W. Va. 25425

11 1988

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies of pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|--|--|---|---|---|--|--|---|--------------------------------|--------------------------------------|---------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Lost | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR | |
| Louie Ernest Giff | | | | | | June 3, 1968 | | | 10:50 PM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | White | | Dec. 23, 1905 | | 62 YRS. | | 5 10 | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. | |
| Antietam, Md. | | U. S. A. | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR
INDUSTRY | |
| Hagerstown | | | Washington Co. Hospital | | | U. S. Marine Corps- | | | Machinist | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | YES | | 317 S. Potomac St. | |
| 14. FATHER'S NAME | | | First | Middle | Lost | 15. MOTHER'S MAIDEN NAME | | | First Middle Lost | |
| Mayberry | | | | | Giff | Martha | | | Holmes | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | Address |
| Yes | | | W. W. Two | | Mr. Walter S. Giff, Rfd. 1, Keedysville, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acc. Cardio. Failure & pulmonary</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4200</u>
(b) <u>Edema - Due - Atherosclerosis heart</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>chronic & Pulmonary Emphysema</u>
20-25 yrs
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
<u>Benign Prostate Hypertrophy</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | County State | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 1, 1968</u> , to <u>June 3, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 3, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edward W. Ditto, III</u> | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6-5-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Edward W. Ditto, III, M.D. | | | | | 22e. ADDRESS
217 W. Wash. St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | (State) | |
| Burial | | 6-7-68 | | Samples Manor Cemetery | | Samples Manor, Wash. Co., Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | | JUN 10 1968 | | <u>Charles Judge</u> | |

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1. *Journal of Management Studies*, 1997, 34, 1, 1-14.

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2013-12-513

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|-----------------------------|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 09087 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 09092 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last
John William Gladwell | | | | | | | | | | Month Day Year
June 27 1968 | | | | | | | | | | M | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years last birthday) | | | | | | | | | | IF UNDER 1 YEAR MONTHS DAYS | | | | | | | | | | IF UNDER 24 HRS. HOURS MIN | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | January 17, 1917 | | | | | | | | | | 51 YRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md | | | | | | | | | | | | | | | | | | | |
| Harrisonburg, Va. | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | | | | | | Washington County Hospital | | | | | | | | | | Locomotive Engineer | | | | | | | | | | Railroad | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | | Hagerstown | | | | | | | | | | YES | | | | | | | | | | 525 Guilford Ave. | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME First Middle Last | | | | | | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Kemp M Gladwell | | | | | | | | | | Edna Virginia Pittington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Yes | | | | | | | | | | 1934-39 1940-43 | | | | | | | | | | 216-14-397 | | | | | | | | | | Mrs. J.W. Gladwell | | | | | | | | | | 525 Guilford Ave. | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) | | | | | | | | | | PART I. DEATH WAS CAUSED BY: | | | | | | | | | | IMMEDIATE CAUSE (a) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 430.9 | | | | | | | | | | Terminal Pneumonia | | | | | | | | | | 5 Days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (b) Subarachnoid Hemorrhage | | | | | | | | | | 10 Days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | (c) Aneurysm of Cerebral Artery | | | | | | | | | | ? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | | 330x | | | | | | | | | | None | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? YES | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 6/17/68 | | | | | | | | | | Subarachnoid Hemorrhage | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 12, 1968 to June 27, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J.H. Poye, M.D. | | | | | | | | | | 6/27/68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| J.H. Poye, M.D. | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 6/30/68 | | | | | | | | | | Rest Haven Cemetery | | | | | | | | | | Hagerstown-Washington-Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Wm. G. Mont | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | JUL - 1 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

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CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|---|---|---|--|---|---|
| 1. DECEASED-NAME
(Type or print) William Windy Godlove | | | 2a. DATE OF DEATH
Month June Day 27 , 19 68 Year | | | 2b. HOUR
7 A.M. | |
| 3. SEX
male | | 4. RACE
white | | 5. DATE OF BIRTH
July 22, 1899 | | 6. AGE (In years last birthday)
68 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Nebraska | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
RFD 5 | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
railroad | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 13e. STREET AND NUMBER
RFD 5 | | | | | | | |
| 14. FATHER'S NAME
First James C. Middle Godlove Last | | | 15. MOTHER'S MAIDEN NAME
First Mary A. Middle Roach Last | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
705-12-2065 | | 17. INFORMANT
Address
Katherine Godlove, Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Malignancy of Larynx - Metastasis
1619
DUE TO, OR AS A CONSEQUENCE OF
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
6 mos. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
161X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
of work <input type="checkbox"/> of work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
<i>Arturo M. Reigo</i> | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/27/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Arturo M. Reigo | | 22e. ADDRESS
159 W. Washington, Hag., Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-30-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown, Md. | |
| 24. FUNERAL DIRECTOR
ADDRESS
Minnich Funeral Home, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR
JUL - 1 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF STATE

June 27, 1966

Godlove

Windy

William

28

July 12, 1966

White

White

Washington

USA

Washington

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Washington

Washington

Washington

Mary A. Godlove

James C. Godlove

Washington, D.C.

703-12-2005

no

120 W. Washington, Ind., Ind.

Arthur M. Hoff

6-20-68 West Haven Cemetery

burial

101-1-1208

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|--|--|---|--|--|-----------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
EDGAR | | | Middle
LEE | | | Last
GROVE | | | 2a. DATE OF DEATH
Month 8 Day 9 Year 68 | | | 2b. HOUR
M | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
APRIL 1 1885 | | | 6. AGE (In years
lost birthday)
83 YRS. | | | IF UNDER 1 YEAR
MONTHS
DAYS | | | IF UNDER 24 HRS.
HOURS
MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON | | | Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
WASHINGTON COUNTY | | | 12a. USUAL OCCUPATION (Kind of work done
during most working life, even if retired.)
SALESMAN | | | 12b. KIND OF BUSINESS OR
INDUSTRY
PRETZEL | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
MD | | | 13b. COUNTY
WASHINGTON | | | 13c. CITY OR TOWN
HAGERSTOWN | | | 13d. INSIDE CITY LIMITS?
<input type="checkbox"/> X <input type="checkbox"/> | | | 13e. STREET AND NUMBER
755 W. WASHINGTON | | | | | |
| 14. FATHER'S NAME
First
DANIEL | | | Middle
J | | | Last
GROCE | | | 15. MOTHER'S MAIDEN NAME
First
CHRISTINE | | | Middle
STECK | | | Last | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown)
NO | | | 16b. SOCIAL SECURITY NO.
218 30 9629A | | | 17. INFORMANT
MARY S GROVE | | | Address
HAGERSTOWN, MD. | | | 755 W. WASHINGTON ST. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arterio sclerotic heart disease</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>years</u> | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4200 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (At home, farm, street, factory,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>66</u> , to <u>June 8</u> , 19 <u>68</u> , that (I) (we) last
saw the deceased alive on <u>June 8</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edwin D Hoachlond</u> | | | DEGREE
ATTENDING
PHYS.
<input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
6/10/68 | | | | | | | | | | | |
| 22d. PHYSICIAN'S
NAME (Type)
<u>Edwin D Hoachlond</u> | | | 22e. ADDRESS
<u>Hagerstown Md.</u> | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL
BURIAL | | | 23b. DATE
6.12.68 | | | 23c. NAME OF CEMETERY OR CREMATORY
RIVER VIEW | | | 23d. LOCATION (City or Town) (County) (State)
WILLIAMSPORT WASHINGTON MD | | | | | | | | |
| 24. FUNERAL DIRECTOR
<u>Howard F Shore Hagerstown Md</u> | | | | | | ADDRESS | | | 25a. REC'D BY REGISTRAR
DATE JUN 13 1968 | | | 25b. REGISTRAR'S SIGNATURE
<u>Charles J. J...</u> | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, Page 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
30M REV. 1/68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|---|--|---|-------------------------------------|---|---|--|---|---|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) ALVEY ELWOOD HANN | | | | | | 2a. DATE OF DEATH
Month JUNE Day 24 Year 1968 | | | 2b. HOUR 1:45 P M | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
NOVEMBER 1, 1918 | | | 6. AGE (In years lost to heavy yrs.)
50 | | IF UNDER 1 YEAR
MONTHS 0 DAYS 0 | | IF UNDER 24 HRS.
HOURS 0 MIN. 0 | |
| 7a. BIRTHPLACE (State or foreign country)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | | | | | |
| 10. CITY OR TOWN OF DEATH
HANCOCK | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
PENNSYLVANIA AVE. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
LABORER | | | 12b. KIND OF BUSINESS OR INDUSTRY
ORCHARD | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HANCOCK | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
PENNA AVE. EXT. | | | |
| 14. FATHER'S NAME First NOT KNOWN Middle NOT KNOWN Last NOT KNOWN | | | | 15. MOTHER'S MAIDEN NAME First VIRGIL Middle VANETTA Last CLARK | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) YES | | | | 16b. SOCIAL SECURITY NO.
W.W. 2 220.09.7386 | | 17. INFORMANT 283 W. MAIN STREET HANCOCK, MD.
JAMES ELWOOD HANN | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4109 Coronary disease
DUE TO, OR AS A CONSEQUENCE OF 7
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) 7
DUE TO, OR AS A CONSEQUENCE OF 7
(c) 7
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minute | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4201 | | | | | | | | | | | | |
| 19a. DATE OF OPERATION
— | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
— | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
— | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. — Month — Day — Year 19
P.M. — | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
— | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
— | | 21f. LOCATION Street or R.F.D. No. — City or Town — County — State — | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 24, 1968 to June 24, 1968 , that (I) (we) last saw the deceased alive on June 24, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | |
| 22b. SIGNATURE
L.M. STAFFER | | | | | | DEGREE — ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/26/68 | | | | |
| 22d. PHYSICIAN'S NAME (Type)
L.M. STAFFER | | | | | | 22e. ADDRESS
HANCOCK, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6/26/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ST. THOMAS EPISCOPAL | | 23d. LOCATION (City or Town) (County) (State)
HANCOCK, WASHINGTON, MD. | | | | | | |
| 24. FUNERAL DIRECTOR
Richard J. Grove | | | | | | ADDRESS
HANCOCK, MD. | | 25a. REC'D BY REGISTRAR
DATE JUN 28 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | |

| | | | | | | |
|-----|---------|-------------|-------------------|-----------------------------------|------------|----------------------|
| YES | W.W. S. | 250.08.7386 | JAMES ELWOOD HANN | 283 W. MAIN STREET
HANOOK, MD. | NOT KNOWN | VIRGIL VANETTA CLARK |
| | | | | | MARYLAND | WASHINGTON |
| | | | HANOOK | X PENNA AVE. EXT. | | |
| | | | PENNSYLVANIA AVE. | LABORER | ORCHARD | |
| | | | U.S.A. | X | WASHINGTON | |
| | | | WHITE | | | NOVEMBER 1, 1919 20 |
| | | | | | | MALE |
| | | | | | | JUNE 24 1908 1:45 |

ST. THOMAS EPISCOPAL CHURCH, WASHINGTON, D.C. 20540

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (1-1)
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|------------------------------|--|---|------------------------------------|---|---|--|---|
| 09091 CERTIFICATE OF DEATH 09096 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| Arthur Cleo Harbaugh | | | | | | Month Day Year
June 13, 1968 | | | 10:55 A.M. |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | 7. UNDER 1 YEAR
MONTHS DAYS | |
| male | | white | | 12-26-1900 | | 67 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | Md. |
| Maryland | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Hagerstown | | | Wash. County Hospital | | | Pharmacist | | | Drug Store |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Md. | | | Wash. | | | Hagerstown | | 872 Mulberry, Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Harry R. Harbaugh | | | Emma Brown | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | 214-09-2347 | | | Mrs. Edna Harbaugh Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF:
(b) <u>Arteriosclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF:
(c) _____
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 hrs.
3 mo. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Sept. 1963</u> , to <u>June 14, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 14, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Lloyd A. Hoffmann</u> DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | | | 22c. DATE SIGNED
6/15/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
Lloyd A. Hoffmann | | | | | | 22e. ADDRESS
Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| Burial | | | 6-15-68 | | Rose Hill Cemetery | | Hagerstown, MD. | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Minnich Funeral Home Hagerstown, Md. | | | | | | DATE JUN 17 1968 | | Charles Judger | |

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CERTIFICATE OF DEATH

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| | | | | | |
|--|-------------------------|--|---|---|---|
| 1. DECEASED-NAME
(Type or print) First Middle Last
Daisy Catherine Hartle | | | 2a. DATE OF DEATH
Month Day Year
June 3, 1968 | | 2b. HOUR
8:00P M |
| 3. SEX
Female | 4. RACE
White | 5. DATE OF BIRTH
Dec. 31, 1891 | | 6. AGE (In years last birthday)
76 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
5 2 |
| 7a. BIRTHPLACE (State or foreign country)
Hagerstown, Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. |
| 10. CITY OR TOWN OF DEATH
Williamsport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Williamsport Sanitarium | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Practical Nurse | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Hagerstown | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
232 E. Washington St. |
| 14. FATHER'S NAME First Middle Last
Barry Hartle | | 15. MOTHER'S MAIDEN NAME First Middle Last
Margaret E. Showe | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service)
No. | | 16b. SOCIAL SECURITY NO.
215-26-2261 | 17. INFORMANT Address
Mr. Clyde R. Miller 249 Mill St. Hagerstown Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) myocardial infarction
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Coronary Arteriosclerosis
DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH:
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 8, 1968 , to _____, 19____, that (I) (we) last saw the deceased alive on May 8, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
F. E. Rosillo | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6-5-68 | |
| 22d. PHYSICIAN'S NAME (Type)
F. E. Rosillo, M. D. | | 22e. ADDRESS
580 Northern Ave., Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-6-68 | 23c. NAME OF CEMETERY OR CREMATORY
Manor Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Tilghmanton, Wash. Co., Md. |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUN 10 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

09898

CERTIFICATE OF DEATH

| | | | | | | | | | | |
|--|--|--|---|---|---|---|---|---|--|--|
| 1. DECEASED-NAME
(Type or print) Hazel ^{First} Catherine ^{Middle} Hastings ^{Last} | | | 2a. DATE OF DEATH
Month June Day 5 Year 1968 | | | 2b. HOUR
7:30AM | | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
11/8/06 | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.)
House Wife | | | 12b. KIND OF BUSINESS OR INDUSTRY
Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
14 Snyder Avenue | |
| 14. FATHER'S NAME ^{First} Albert ^{Middle} ^{Last} Mellotte | | | 15. MOTHER'S MAIDEN NAME ^{First} Georgetta ^{Middle} ^{Last} Long | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no (or unknown) | | | 16b. SOCIAL SECURITY NO.
None | | 17. INFORMANT ^{Address}
David E. Hastings 14 Snyder Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral Thrombosis
2559
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arterial Hypotension
DUE TO, OR AS A CONSEQUENCE OF
(c) Adrenal insufficiency
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3 days
unknown | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
274X | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 4, 1968 , to June 5, 1968 , that (I) (we) last saw the deceased alive on June 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Fe U. Porciuncula M.D. | | | | | DEGREE
M.D. | | ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
June 5, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Fe U. Porciuncula, M.D. | | | | | 22e. ADDRESS
Western Maryland State Hospital | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 7, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
St. Pauls Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Near Clearspring, Md. | | | |
| 24. FUNERAL DIRECTOR
Andrew K. Coffman Funeral Home Inc. | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 7 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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CERTIFICATE OF DEATH

09094

09099

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|--|----------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Washington MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE Penna. b. COUNTY Franklin ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Hagerstown | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Mercersburg, Pa. 17236 | |
| c. LENGTH OF STAY IN 1b
4 weeks | | d. STREET ADDRESS
R.D.2 | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
Washington County Hosp. | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First ELVA Middle MAY Last HAWBAKER | | 4. DATE OF DEATH
Month June Day 30 Year 1968 | |
| 5. SEX
Fem. | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
5/11/1892 |
| 9. AGE (In years last birthday) yrs.
76 | | 10. IF UNDER 1 YEAR
Months 19 Days 19 Hours 19 Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY
Own home | |
| 11. BIRTHPLACE (County & State, or foreign country)
Mercersburg, Pa., R.1 | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
John C. Metcalfe | | 14. MOTHER'S MAIDEN NAME
Laura J. Clapsaddle | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
no | | 16. SOCIAL SECURITY NO.
195-16-3719 | |
| 17. INFORMANT
Luther S. Hawbaker | | Address Pa., R.#2 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART I. DEATH WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)
IMMEDIATE CAUSE (a) Acute Myocardial Infarction
DUE TO (b) Arteriosclerotic Heart Disease
DUE TO (c) not known
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, 4201 | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
Diabetes Mellitus | | | |
| 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. 19 p.m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from May 31, 1968 , to 6/30, 1968 , that (I) (we) last saw the deceased alive on 6/30, 1968 , and that death occurred at 2 P.M. from causes and on the date stated above. | | | |
| 22a. SIGNATURE
[Signature] | | 22b. DATE SIGNED
7/1/68 | |
| 22c. PHYSICIAN'S NAME (Type)
A. M. KIEGO | | 22d. ADDRESS
119 E. Antietam, Hagerstown | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
7/3/68 | |
| 23c. NAME OF CEMETERY OR CREMATORY
Welsh Run Brethren | | 23d. LOCATION (City or Town) (County) (State)
Mercersburg, Pa., R.#2 | |
| 24. FUNERAL DIRECTOR
T. M. Beninger | | 25a. REC'D BY REGISTRAR
JUL - 3 1968 | |
| 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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DEPARTMENT OF STATE

Franklin

Emma

Washington

Washington, D.C. 20530

4 weeks

Harborfront

F.O.S.

Washington County Hosp.

June 30, 1960

NAME

NAME

X

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5/11/1962

Pen. White

USA

Washington, D.C. 20530

own home

Housewife

James J. O'Connell

John C. McCarthy

Pa., D.C.

James J. O'Connell, James J. McCarthy

100-10-1110

no

Washington, D.C. 20530

William R. Hadden

100-10-1110

100-10-1110

Washington, D.C. 20530

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|--|--|--|---|---|--|---|------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | | 2b. HOUR | |
| JAMES | | | WILLIAM | | | JUNE Month 4 Day 68 Year | | | 3 p M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years and birthday) | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| MALE | | WHITE | | AUGUST 14, 1910 | | 68 51 YRS. | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| TENNESSEE | | U.S.A. | | | | WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| HAGERSTOWN | | | WASHINGTON COUNTY | | | SHEET METAL WORKER | | SANDBLAST MFG. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| HAGERSTOWN | | | WASHINGTON | | HAGERSTOWN | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 425 CLARENDON AVE. | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| JOSEPH HEAD | | | ROSA NELL BEARD | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | |
| YES WW 2 | | | 220-10-3089 | | MRS. BONNIE K HEAD 425 CLARENDON AVE HAGERSTOWN, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Myocardial Infarction</u> | | | | | | | | 7 days | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>Coronary artery Dis.</u> | | | | | | | | years | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>Interventricular Card. Dis.</u> | | | | | | | | years | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Previous myocardial infarction, Aspiration pneumonia</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>2 Jan 68</u> , to <u>date</u> , 19 <u>68</u> , that (I) <u>was</u> last saw the deceased alive on <u>4 June</u> 19 <u>68</u> and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did</u> (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Richard T. Binford</u> | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED <u>6/5/68</u> | | | | |
| 22d. PHYSICIAN'S NAME (Type) RICHARD T. BINFORD, M.D. | | | | 22e. ADDRESS <u>1135 POTOMAC AVE., HAGERSTOWN, MD.</u> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| BURIAL | | 6/8/68 | | MONTE VISTA CEMETERY | | JOHNSON CITY, WASHINGTON, TENN. | | | | |
| 24. FUNERAL DIRECTOR <u>Charles M. Rouse</u> | | | | ADDRESS HAGERSTOWN, MD. | | 25a. REC'D BY REGISTRAR DATE <u>JUN 7 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | |
|---|--|--|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) Mary Elizabeth Hill | | | 2a. DATE OF DEATH
Month June Day 24 Year 1968 | | | 2b. HOUR
6:50 p.m. | |
| 3. SEX
Female | | 4. RACE
Colored | | 5. DATE OF BIRTH
Nov 13 1919 | | 6. AGE (In years last birthday)
48 YRS. | |
| 7a. BIRTHPLACE (State or foreign country)
Carlisle, Pa. | | 7b. CITIZEN OF WHAT COUNTRY?
USA. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown Md | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington County Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY
Private fam. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET AND NUMBER
669 Forrest Dr. | | | | | | | |
| 14. FATHER'S NAME
First James Middle D Last Ramsey | | | 15. MOTHER'S MAIDEN NAME
First Anna Middle B Last Dennis | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO.
171-28-4182 | | 17. INFORMANT
Address Calvin R. Hill 669 Forrest Dr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Metastatic brain tumor
1929
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Esthesioneuroblastoma
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Approx. 3 mo.
Eleven yrs. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(c)
1934 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 18 1967 , to June 24 1968 , that (I) (was) saw the deceased alive on June 24 1968 , and that in (my) (her) opinion death occurred on the date and hour and from the causes stated above, (I) (was) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE
Donald E. Martin M.D. | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/25/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Donald E. Martin, M.D. | | 22e. ADDRESS
363 S. Cleveland Ave., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-28-1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Rose Hill Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Md. | |
| 24. FUNERAL DIRECTOR
John R. Watson Jr. Hagerstown Md | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

1010

STATE OF TEXAS

22030

IN SENATE

January 1, 1901

REPORT

OF THE

COMMISSIONER OF THE

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FOR THE YEAR

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304 REV. 1-68

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--------------------------|---|--|--|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| William Maxwell Hungate | | | | | | Month Day Year
June 24, 1968 | | 8A -M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years
last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| male | | white | | 9-26-1907 | | 60 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Maryland | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | |
| Hagerstown | | 1515 W. Church, St. | | Switchboard Opera. | | City, Gov. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Wash. | | Hagerstown | | | | 1515 W. Church, St. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Charles T. Hungate | | | Bessie Snyder | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| no | | | 214-09-2607 | | | Mrs. Helen M. Hungate Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>acute myocardial failure</u>
DUE TO, OR AS A CONSEQUENCE OF <u>intermittent cardiac Dis.</u>
CONDITIONS, IF ANY, WHICH GAVE
RISE TO IMMEDIATE CAUSE (a),
STATING THE UNDERLYING CAUSE
LAST. <u>4227</u>
(b) <u>intermittent cardiac Dis.</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>intermittent cardiac Dis.</u> | | | | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
<u>2-3 wks</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I.
<u>Rheumatic heart disease; aortic stenosis Emphysema</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>26 Dec 67</u> , to <u>31 Mar 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Richard T. Binford, M.D.</u> | | | | 22c. DATE SIGNED
24 June 68 | | | | | |
| 22d. PHYSICIAN'S
NAME (Type) | | | | 22e. ADDRESS | | | | | |
| Richard T. Binford, M. D. | | | | 1135 Potomac Ave., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6-27-1968 | | Rose Hill Cemetery | | Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | JUN 27 1968 | | Charles Judge | | | |

CERTIFICATE OF DEATH

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09103

| | | | | | | | | | | | |
|---|--|------------------------------|--|---|---|---|--|---|--|---|--|
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Charles | | | Kendle | Keadle | June 7 1968 | | | 6:30P M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| Male | | White | | April 23, 1900 | | 68 | | MONTHS 1 DAYS 14 | | HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Mapleville, Md. | | U. S. A. | | | | Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Boonsboro Rfd. 2, Md. | | | | | | Clerk | | | Hardware | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Boonsboro | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | Rfd. 2 | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | | |
| James R. Keadle | | | Rosa Nunamaker | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, go, or (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | | |
| No. | | | 214-09-1366 | | Mrs. Pauline Keadle, Rfd. 2, Boonsboro, Md. | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Myocardial Infarction | | | | | | | | | | | Minutes |
| DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic heart disease | | | | | | | | | | | Indef. |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4201 | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | HOUR A.M. Month Day Year P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1958, to death, 19, that (I) (we) last saw the deceased alive on June 7 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Robert T. Keadle | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type) Robert T. Keadle | | | | | | 22c. DATE SIGNED 6-9-68 | | | | | |
| 22e. ADDRESS Hagerstown, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 6-10-68 | | Boonsboro Cemetery | | | Boonsboro, Wash. Co., Md. | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | | | | | JUN 12 1968 | | J. Charles Jones | |

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Keller Daisy J.</i> | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year
<i>June 13 1968</i> | | | 2b. HOUR
<i>4 P.M.</i> | | |
| 3. SEX
<i>Female</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>February 23, 1889</i> | | | 6. AGE (In years last birthday)
<i>79</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Frederick, Md.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>United States</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Washington</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Williamsport, Md.</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Homewood Church Home, Inc.</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>housewife</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>was Frederick</i> | | | 13c. CITY OR TOWN
<i>Middletown</i> | | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME
First Middle Last
<i>Silas A. Thomas</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Katherine C. Conrad</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) (If yes give war or dates of service)
<i>No</i> | | | 16b. SOCIAL SECURITY NO.
<i>219-54-0855</i> | | |
| 17. INFORMANT
<i>Mark E. Wagner</i> | | | 17a. ADDRESS
<i>2750 Virginia Avenue, Williamsport, Md.</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Generalized Carcinomatosis</i>
<i>1631</i>
DUE TO, OR AS A CONSEQUENCE OF
(b) <i>CA of Hyperplasia</i>
DUE TO, OR AS A CONSEQUENCE OF
(c) <i>2 years</i> | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>6 mos.</i> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
<i>164X Hypertension & V.D.</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>July</i> , 19 <i>65</i> , to <i>6-13</i> , 19 <i>68</i> , that (I) (we) last saw the deceased alive on <i>6-13</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Robert P. Conrad</i> | | | DEGREE
<i>Robert P. Conrad, M.D.</i> | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>6-14-68</i> | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Robert P. Conrad, M.D.</i> | | | 22e. ADDRESS
<i>137 W. Washington St., Hagerstown, Md.</i> | | | 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>burial</i> | | | 23b. DATE
<i>6/15/68</i> | | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Reformed Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Middletown, Fred., Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>JUN 18 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles J. Jager</i> | | |
| 24. FUNERAL DIRECTOR
<i>Gladhill Funeral Home, Middletown, Maryland</i> | | | | | | | | | | | |

20120

MINISTRE DE LA SÉCURITÉ

20120

17 JAN 1971

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1000

1000



MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09100

09105 Noon

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| | | | | | | | |
|--|-------------------------|--|-------------------------|---|---|---|---|
| 1. DECEASED-NAME
(Type or Print) | | First
David | Middle
Luther | Last
King | 2a. DATE KNOWN
OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> June 22, 1968 | | 2b. HOUR
7:40 P. |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
April 15, 1940 | | 6. AGE (In years
by birthday)
28 YRS. | IF UNDER 1 YEAR
MONTHS
0 DAYS
0 | IF UNDER 24 HRS.
HOURS
0 MIN
0 | 2c. DATE PRONOUNCED DEAD
June 22 day Year 1968 |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington | |
| 10. CITY OR TOWN OF DEATH
Hagerstown Md. | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Washington County Concrete Mason | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
Masonry | | 12b. KIND OF BUSINESS OR
INDUSTRY |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
deceased STATE)
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
RFD 2, Williamsport | | 13d. INSIDE CITY LIMITS?
0 | |
| 14. FATHER'S NAME
First
Harry | | Middle
Luther | Last
King | 15. MOTHER'S MAIDEN NAME
First
Dorothy | | Middle
Louise | Last
Reed |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
219-36-3346 | | 17. INFORMANT
Mrs. Gloria King | | ADDRESS
RFD 2, Williamsport | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Drowning.
830.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Few minutes | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
850 X | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>
CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M.
Noon P.M. 6-22- 1968 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fell from boat while fishing. | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Little Pool, 3 mi. East of | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Hancock, Washington, Maryland | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE
H. E. W. Ditto, Jr. | | EXAMINER'S NAME (Type)
Dr. E. W. Ditto, Jr. | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | 22b. DATE SIGNED
June 24, 1968 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 25, 68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cedar Lawn Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown Wash. Md. | |
| 24. FUNERAL DIRECTOR
Donald E. Thompson | | | | ADDRESS
Thompson Funeral Home Clear Spring, Md. | | 25a. REC'D BY REGISTRAR
JUN 27 1968 | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

| | | | | |
|-------|-------|--------------|------|-------------|
| Male | White | April 12, 40 | SS | June 22, 63 |
| David | White | June 22, 63 | King | June 22, 63 |

| | | | | | |
|-----------|------------|--------------------|-------------------|----------------|---------|
| Harryland | Washington | RD 2, Williamsport | Washington County | Conover's Road | Memphis |
|-----------|------------|--------------------|-------------------|----------------|---------|

| | | | | | |
|-------|-------|------|----------|--------|------|
| Harry | White | King | Donnelly | Louise | Head |
|-------|-------|------|----------|--------|------|

| | | | | |
|----|------------|------------------|----|--------------|
| No | 219-36-354 | Mrs. Gloria King | SS | Williamsport |
|----|------------|------------------|----|--------------|

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| Williamsport | PA | 1700 |
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| Williamsport | PA | 1700 |
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| Williamsport | PA | 1700 |
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| Williamsport | PA | 1700 |
|--------------|----|------|

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers, Pages 4 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|--|---|---|--|--------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 09101 | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | | |
| William Edward King, Jr. | | | | | | Month Day Year | | M | | |
| 3. SEX | | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | | White | | August 18, 1927 | | 40 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Hagerstown, Md. | | USA | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | 405 Ridge Ave. | | | Foreman | | Shoe Mfg. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | | | 405 Ridge Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| William Edward King, Sr. | | | Ethel Louise Fisher | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| Yes | | | 220-16-3045 | | Mrs. Mary Jane Skipper | | 405 Ridge Ave. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Congestive Heart Failure | | | | | | | | | | |
| 425X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (b) Myocardopathy | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | |
| (c) 2 years | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | |
| Gout | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10, 1968, to 6/14/68, 1968, that (I) (we) last saw the deceased alive on 6/14, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | | | 22c. DATE SIGNED | | | | | |
| A. Mandell, M.D. | | | | | 6/24/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | 22e. ADDRESS | | | | | |
| ANDREW M. MANDELL, M.D. | | | | | 301 E. ANTIETAM ST. HAGERSTOWN, MARYLAND | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| Burial | | 6/25/68 | | Rest Haven Cemetery | | Hagerstown-Washington Md. | | | | |
| 24. FUNERAL DIRECTOR | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Wm. A. Horst | | | | | JUN 26 1968 | | Charles Judge | | | |
| Rest Haven Funeral Chapel | | | | | Hagerstown, Md. | | | | | |

00100

00100

RECEIVED

William (Chief) King, Jr.

March 18, 1957

Washington

202 4th St.

Washington

William (Chief) King, Jr.

202 4th St.

March 18, 1957

Washington

202 4th St.

March 18, 1957

William (Chief) King, Jr.
202 4th St.
Washington

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

09102

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

09107

| | | | | | | | | |
|--|--|--|---|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) CARL | | | 2a. DATE OF DEATH
JUNE Month 26 Day 1968 | | | 2b. HOUR
5:05 P.M. | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
10/31/1882 | | |
| 6. AGE (In years
lost birthday)
85 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign
country)
PENNSYLVANIA | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 9. COUNTY OF DEATH
WASHINGTON | | | 10. CITY OR TOWN OF DEATH
WILLIAMS PORT | | | 11. NAME OF HOSPITAL OR INSTITUTION
SANTARIUM | | |
| 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired)
RETIRED WATCH MAKER | | | 12b. KIND OF BUSINESS OR
INDUSTRY
SHOP | | | 13a. CITY OR TOWN
HAGERSTOWN | | |
| 13b. COUNTY
WASHINGTON | | | 13c. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13d. STREET AND NUMBER
RT.#1 HAGERSTOWN MD. | | |
| 14. FATHER'S NAME
JOSEPH S. KLOCK | | | 15. MOTHER'S MAIDEN NAME
CATHERINE ANN BORDNER | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown) NO | | |
| 16b. SOCIAL SECURITY NO.
215-20-9642 | | | 17. INFORMANT
MR. RONALD KLOCK HAGERSTOWN MD. | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Pneumonia RLL
4109
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
And Myocardial Infarction
DUE TO, OR AS A CONSEQUENCE OF
Coronary heart disease
indefinite | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
4201 | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-19 , 19 61 , to death , that (I) (we) lost saw the deceased alive on 6-26 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE
Robert F. Keadle | | | 22c. DATE SIGNED
6-28-68 | | | 22d. PHYSICIAN'S NAME (Type)
Robert F. Keadle | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | | 23b. DATE
6/29/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
LUTHERN & REFORMED CHURCH | | |
| 24. FUNERAL DIRECTOR
W. F. Norman | | | 25a. REC'D BY REGISTRAR
11-1-1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

70183

10/10/50

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 10-1 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|------------------------------------|---|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| 09103 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Frank Emerson Knapp Jr. | | | | | | Month Day Year
June 20, 1968 | | 2 a.m. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| male | | white | | 7-12-1916 | | 51 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Pennsylvania | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | 1020 Columbia, Road. | | Clerk | | Railroad | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Md. | | Wash. | | Hagerstown | | | | 1020 Columbia, Road | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last
Frank E. Knapp Sr. | | | First Middle Last
Mary Suttliff | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| Yes <input checked="" type="checkbox"/> WW II | | | 214-09-2378 | | | Mrs. Anna Lee Knapp Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Coronary occlusion</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Atherosclerotic coronary disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
4109 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
sudden
sev. yrs. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Feb.</u> , 19 <u>59</u> , to <u>June</u> , 19 <u>68</u> , that (I) (we) lost the deceased alive on <u>5/1/</u> 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | | | | | | |
| <i>Howard N. Weeks</i> | | 6/21/68 | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| Howard N. Weeks, M.D. | | 580 Northern Ave., Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6-22-1968 | | Rest Haven Cemetery | | Hagerstown, Md. | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | DATE JUN 24 1968 | | <i>Charles Judge</i> | | | |

MEDICAL CERTIFICATION

of the

editors

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | |
|---|--|---|--|--|---|
| 1. DECEASED-NAME
(Type or print) William Frank Kooken | | | 2a. DATE OF DEATH
Month June Day 19 Year 1968 | | 2b. HOUR
2:20
A. M. |
| 3. SEX
male | 4. RACE
white | 5. DATE OF BIRTH
April 7, 1880 | | 6. AGE (In years
last birthday)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. |
| 7a. BIRTHPLACE (State or foreign
country)
Maryland | 7b. CITIZEN OF WHAT COUNTRY?
USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Washington Md. | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Avalon Manor Nurs H. | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Carpenter | 12b. KIND OF BUSINESS OR
INDUSTRY
Construction | | |
| 13a. USUAL RESIDENCE (Where deceased
admission) STATE
Maryland | 13b. CITY OR TOWN
Washington | 13c. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET AND NUMBER
10 E. Baltimore St. | | |
| 14. FATHER'S NAME
First Issac Middle Kooken Last | | 15. MOTHER'S MAIDEN NAME First Alice Middle Kight Last | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) no (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
215-14-6384 | 17. INFORMANT
Address
Mrs. Laura Kooken, Hagerstown, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(b) Arteriosclerosis Generalized.
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave
rise to immediate cause (a),
stating the underlying cause
last. | | | | | APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH
3 days.
2 hrs + |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
332X | | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 18, 1968 , to June 18, 1968 , that (I) (we) last
saw the deceased alive on June 18, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the
causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE
Charles A. Hoffman DEGREE
22d. PHYSICIAN'S
NAME (Type) Dr. A. Hoffman | | ATTENDING
PHYS. <input checked="" type="checkbox"/> MED.
DIRECTOR <input type="checkbox"/> STAFF
PHYS. <input type="checkbox"/> | 22c. DATE SIGNED
6/19/68 | | |
| 22e. ADDRESS
214 N. Pot. St. Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | 23b. DATE
6-21-68 | 23c. NAME OF CEMETERY OR CREMATORY
Philos Cemetery | 23d. LOCATION (City or Town) (County) (State)
Westernport, Md. | | |
| 24. FUNERAL DIRECTOR
Boal's Funeral Service, | | ADDRESS
Westernport, Md. | 25a. REC'D BY REGISTRAR
DATE JUN 24 1968 | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

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• *See also* 100-101, 102, 103, 104, 105, 106, 107, 108, 109, 110, 111, 112, 113, 114, 115, 116, 117, 118, 119, 120, 121, 122, 123, 124, 125, 126, 127, 128, 129, 130, 131, 132, 133, 134, 135, 136, 137, 138, 139, 140, 141, 142, 143, 144, 145, 146, 147, 148, 149, 150, 151, 152, 153, 154, 155, 156, 157, 158, 159, 160, 161, 162, 163, 164, 165, 166, 167, 168, 169, 170, 171, 172, 173, 174, 175, 176, 177, 178, 179, 180, 181, 182, 183, 184, 185, 186, 187, 188, 189, 190, 191, 192, 193, 194, 195, 196, 197, 198, 199, 200, 201, 202, 203, 204, 205, 206, 207, 208, 209, 210, 211, 212, 213, 214, 215, 216, 217, 218, 219, 220, 221, 222, 223, 224, 225, 226, 227, 228, 229, 230, 231, 232, 233, 234, 235, 236, 237, 238, 239, 240, 241, 242, 243, 244, 245, 246, 247, 248, 249, 250, 251, 252, 253, 254, 255, 256, 257, 258, 259, 260, 261, 262, 263, 264, 265, 266, 267, 268, 269, 270, 271, 272, 273, 274, 275, 276, 277, 278, 279, 280, 281, 282, 283, 284, 285, 286, 287, 288, 289, 290, 291, 292, 293, 294, 295, 296, 297, 298, 299, 300, 301, 302, 303, 304, 305, 306, 307, 308, 309, 310, 311, 312, 313, 314, 315, 316, 317, 318, 319, 320, 321, 322, 323, 324, 325, 326, 327, 328, 329, 330, 331, 332, 333, 334, 335, 336, 337, 338, 339, 340, 341, 342, 343, 344, 345, 346, 347, 348, 349, 350, 351, 352, 353, 354, 355, 356, 357, 358, 359, 360, 361, 362, 363, 364, 365, 366, 367, 368, 369, 370, 371, 372, 373, 374, 375, 376, 377, 378, 379, 380, 381, 382, 383, 384, 385, 386, 387, 388, 389, 390, 391, 392, 393, 394, 395, 396, 397, 398, 399, 400, 401, 402, 403, 404, 405, 406, 407, 408, 409, 410, 411, 412, 413, 414, 415, 416, 417, 418, 419, 420, 421, 422, 423, 424, 425, 426, 427, 428, 429, 430, 431, 432, 433, 434, 435, 436, 437, 438, 439, 440, 441, 442, 443, 444, 445, 446, 447, 448, 449, 450, 451, 452, 453, 454, 455, 456, 457, 458, 459, 460, 461, 462, 463, 464, 465, 466, 467, 468, 469, 470, 471, 472, 473, 474, 475, 476, 477, 478, 479, 480, 481, 482, 483, 484, 485, 486, 487, 488, 489, 490, 491, 492, 493, 494, 495, 496, 497, 498, 499, 500, 501, 502, 503, 504, 505, 506, 507, 508, 509, 510, 511, 512, 513, 514, 515, 516, 517, 518, 519, 520, 521, 522, 523, 524, 525, 526, 527, 528, 529, 530, 531, 532, 533, 534, 535, 536, 537, 538, 539, 540, 541, 542, 543, 544, 545, 546, 547, 548, 549, 550, 551, 552, 553, 554, 555, 556, 557, 558, 559, 560, 561, 562, 563, 564, 565, 566, 567, 568, 569, 570, 571, 572, 573, 574, 575, 576, 577, 578, 579, 580, 581, 582, 583, 584, 585, 586, 587, 588, 589, 590, 591, 592, 593, 594, 595, 596, 597, 598, 599, 600, 601, 602, 603, 604, 605, 606, 607, 608, 609, 610, 611, 612, 613, 614, 615, 616, 617, 618, 619, 620, 621, 622, 623, 624, 625, 626, 627, 628, 629, 630, 631, 632, 633, 634, 635, 636, 637, 638, 639, 640, 641, 642, 643, 644, 645, 646, 647, 648, 649, 650, 651, 652, 653, 654, 655, 656, 657, 658, 659, 660, 661, 662, 663, 664, 665, 666, 667, 668, 669, 670, 671, 672, 673, 674, 675, 676, 677, 678, 679, 680, 681, 682, 683, 684, 685, 686, 687, 688, 689, 690, 691, 692, 693, 694, 695, 696, 697, 698, 699, 700, 701, 702, 703, 704, 705, 706, 707, 708, 709, 710, 711, 712, 713, 714, 715, 716, 717, 718, 719, 720, 721, 722, 723, 724, 725, 726, 727, 728, 729, 730, 731, 732, 733, 734, 735, 736, 737, 738, 739, 740, 741, 742, 743, 744, 745, 746, 747, 748, 749, 750, 751, 752, 753, 754, 755, 756, 757, 758, 759, 760, 761, 762, 763, 764, 765, 766, 767, 768, 769, 770, 771, 772, 773, 774, 775, 776, 777, 778, 779, 780, 781, 782, 783, 784, 785, 786, 787, 788, 789, 790, 791, 792, 793, 794, 795, 796, 797, 798, 799, 800, 801, 802, 803, 804, 805, 806, 807, 808, 809, 810, 811, 812, 813, 814, 815, 816, 817, 818, 819, 820, 821, 822, 823, 824, 825, 826, 827, 828, 829, 830, 831, 832, 833, 834, 835, 836, 837, 838, 839, 840, 841, 842, 843, 844, 845, 846, 847, 848, 849, 850, 851, 852, 853, 854, 855, 856, 857, 858, 859, 860, 861, 862, 863, 864, 865, 866, 867, 868, 869, 870, 871, 872, 873, 874, 875, 876, 877, 878, 879, 880, 881, 882, 883, 884, 885, 886, 887, 888, 889, 890, 891, 892, 893, 894, 895, 896, 897, 898, 899, 900, 901, 902, 903, 904, 905, 906, 907, 908, 909, 910, 911, 912, 913, 914, 915, 916,

U.S. Service, Washington, D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | |
|---|--|--|-----------------------|---|--|---|--|--|----------------------------------|
| 1. DECEASED-NAME
(Type or print) | | First
LILLIAN | Middle
BARR | Last
KRIDLER | 2a. DATE OF DEATH
JUNE Month 5 Day 1968 Year | | 2b. HOUR
3 A M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1/14/1898 | | 6. AGE (In years last birthday)
70 YRS. | | IF UNDER 1 YEAR
MONTHS
DAYS | IF UNDER 24 HRS.
HOURS
MIN |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)
WASHINGTON CO. HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done)
SEAMSTRESS DRESS SHOP | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
258 S. LOCUST ST. | |
| 14. FATHER'S NAME
First
HARVEY | | Middle
D. | | Last
KRIDLER | | 15. MOTHER'S MAIDEN NAME
First
IDA | | Middle
VIRGINIA Last
CHAPMAN | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown
NO | | (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
214-29-3355 | | 17. INFORMANT
Address
HAGERSTOWN MD.
MR. ROBERT D. KRIDLER | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial infarction
4109
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Coronary Thrombosis
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
5 days
5 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4201 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from May 29 , 19 67 , to June 5 , 19 68 , that (I) (we) last saw the deceased alive on June 5 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Dorothy A. Hoffman | | DEGREE
DEGREE | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
Dorothy A. Hoffman | | 22e. ADDRESS
214 N. Potomac St. Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition of body
BURIAL | | 23b. DATE
6/6/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | |
| 24. FUNERAL DIRECTOR
W. J. Norman, Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 10 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. ... | | | |

60202

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-9. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| 1. DECEASED-NAME
(Type or Print) | | | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
|--|--|---------|--|--|--|---------------------------------|--|--|--|-------------------------|--|---|--|
| Irvin Martin Lee | | | | | | | | | | June 1 1968 | | 6:50 P.M. | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | | 2c. DATE PRONOUNCED DEAD | |
| Male | | White | | 7/18/17 | | 50 YRS. | | MONTHS DAYS | | HOURS MIN. | | Month 6- Day 1- Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH | |
| Hampshire W.VA. | | | | U.S.A. | | | | | | | | Washington Md. | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Clear Spring | | | | N. Martin St. | | | | Railroad carman | | | | W. Md. R.R. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | | Washington | | | | Clear Spring | | | | N. Martin St. | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | |
| John Santa Lee | | | | Lillie # Wilkens | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT | | | | ADDRESS | |
| No | | | | None | | | | 236-20-9427 | | | | Patsy Darlene Lee Clear Spring, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Pending/ Acute Hemorrhagic Pancreatic Necrosis recent | | | | | | | | | | | | | |
| 5770 | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | |
| 5870 | | | | | | | | | | | | | |
| (b) Acute Hemorrhagic Duodenopathy, Diffuse | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | |
| Acute Ethanol Intoxication | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | HOUR A.M. P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED | | | | | |
| EXAMINER'S NAME (Type) | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | 6-3-68 | | | | | |
| Dr. E. W. Ditto, Jr. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | 25a. REC'D BY REGISTRAR | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | |
| Burial | | | | 6/5/68 | | | | Greenlane Cemetery Delray W. Va. | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25b. REGISTRAR'S SIGNATURE | | | | DATE | | | | | |
| Margaret Rowland, Clear Spring, Md. | | | | Charles Judge | | | | JUN 5 1968 | | | | | |

03103

11112

June 1, 1968
Clear Spring, Md.
Dear Sir:
Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.
Very truly yours,
[Signature]
Special Agent in Charge

Enclosure

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Edna Ruth Linn | | | 2a. DATE OF DEATH
6 Month 1 Day 68 Year | | | 2b. HOUR
5:20 M | | | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
Oct, 26, 1895 | | 6. AGE (In years
last birthday)
72 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | |
| 7a. BIRTHPLACE (State or foreign
country) Penna. | | 7b. CITIZEN OF WHAT COUNTRY?
UAS | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
Wash. Co. Hospital | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
processor | | 12b. KIND OF BUSINESS OR
INDUSTRY
Gan depot | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Md. | | 13b. COUNTY
Wash. | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
108 E. Washington St. | |
| 14. FATHER'S NAME First Middle Last
Daniel Gamble | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Anna Sutton | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO.
173-14-1695A | | 17. INFORMANT
Alvin Linn | | Address
Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 1538 liver metastasis
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 1538
(b) Carcinoma of Colon
DUE TO, OR AS A CONSEQUENCE OF
(c) 3 mo? | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Diabetes Mellitus, Generalized arteriosclerosis | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/26/68 , to 6/1/68 , that (I) (we) last saw the deceased alive on 5/31/68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
Wm O. Ryke | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/3/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-5-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Pine Grove Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Neelyton Penna. | | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home | | | | ADDRESS
Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
JUN 4 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

0120

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|-------------------|---|--|---|--------------------------|--|-------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | 2b. HOUR | | | |
| Susan Jane Main | | | | | | June 30 1968 | | 6:00P.M. | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | | |
| Female | | White | | Dec. 6, 1880 | | 87 YRS. | | MONTHS DAYS HOURS MIN | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | IF UNDER 24 HRS. | | | |
| Middletown, Md. | | U. S. A. | | | | Washington | | Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Washington Co. Hospital | | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Keedysville | | | | Rfd. 1 | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Henry Kephart | | | | | | Francis Younkens | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address | | |
| No. | | | None | | | Mrs. Welty Nicodemus | | | Rfd. 1, Keedysville, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>Chronic congestive heart failure</u> | | | | | | | | | | years | |
| 4409 DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> | | | | | | | | | | years | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 4500 <u>Hepatic & renal</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| | | HOUR A.M. Month Day Year | | | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION | | Street or R.F.D. No. | | City or Town | | County | State |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 27, 1968</u> , to <u>June 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 30, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Joseph Secondari</u> | | | | | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| | | | | | | | | | | 7-1-68 | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | 22e. ADDRESS | | | | | |
| Joseph Secondari, M.D. | | | | | | 21 N. Main St., Boonsboro, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) | | (State) | |
| Burial | | 7-3-68 | | Boonsboro Cemetery | | Boonsboro, Wash. Co., Md. | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| John H. Bast, Jr. | | | | | | 1112 N. Main St. Boonsboro, Md. | | JUL - 5 1968 | | <u>Charles Judge</u> | |

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03113

MINUTE OF MEETING

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then (these) remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|--|--|--|--|--|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
RUSSELL | | | Middle
STANLEY | | | Last
MANNING | | |
| 3. SEX
MALE | | | 4. RACE
WHITE | | | 5. DATE OF BIRTH
3.18.1895 | | | 2a. DATE OF DEATH
6 Month 11 Day 68 Year | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON COUNTY | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
FARMING (RETIRED) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
PENNA. | | | 13b. COUNTY
FULTON | | | 13c. CITY OR TOWN
WARFORDSBURG PA | | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | |
| 14. FATHER'S NAME
CHARLES | | | First
MANNING | | | 15. MOTHER'S MAIDEN NAME
CARRIE | | | First
MCULLOUGH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) NO | | | 16b. SOCIAL SECURITY NO.
NONE | | | 17. INFORMANT
VIDA L MANNING WARFORDSBURG PENNA. | | | Address | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Rupture of aneurysm of Rt. Aorta artery</u>
4129
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Generalized arteriosclerosis</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>4500 Arteriosclerosis Heart Disease</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION
Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June</u> , 19 <u>68</u> , to <u>June</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>June</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Edson B. Moody</u> | | | DEGREE
EDSON B. MOODY | | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
6-14-68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Edson B. Moody, M.D. | | | 22e. ADDRESS
363 S. Cleveland Ave. Hagerstown, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMAINS
BURIAL | | | 23b. DATE
6.15.68 | | | 23c. NAME OF CEMETERY OR CREMATORIUM
PRESBYTERIAN | | | 23d. LOCATION (City or Town) (County) (State)
WARFORDSBURG FULTON PENNA | | |
| 24. FUNERAL DIRECTOR
Howard & Elmore Hancock Inc | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 19 1968 | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Young</u> | | | |

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RUSSELL STANLEY HANNING

MALE WHITE 3.18.1902

MARYLAND U.S.A. WASHINGTON

JACKSONVILLE WASHINGTON COUNTY (RETIRED)

ROMA, ITALY WARFORDSHIRE PA

CHARLES HANNING GABRIEL

WOMEN VIDA L. HANNING WARFORDSHIRE PENNA.

BUILD 6.12.68 PRESBYTERIAN

APR 10 1968

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
| 091120 CERTIFICATE OF DEATH 09115 | | | | | | | | | | |
| 1. DECEASED-NAME (Type or print) Leila GAYNELL MARTIN | | | | | 2a. DATE OF DEATH
June Month 23 Day Year 1968 | | 2b. HOUR M | | | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Jan. 7 1925 | | 6. AGE (In years last birthday)
43 YRS. | | IF UNDER 1 YEAR MONTHS 5 DAYS 15 IF UNDER 24 HRS. HOURS 24 MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
Washington USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | | |
| 1d. CITY OR TOWN OF DEATH
Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Washington Co. Hospital | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Bookkeeper | | 12b. KIND OF BUSINESS OR INDUSTRY
Auto Parts | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER
RFD #4 | |
| 14. FATHER'S NAME First Peter Middle L Last Martin | | | 15. MOTHER'S MAIDEN NAME First Helen Middle Last Shabk | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No | | | 16b. SOCIAL SECURITY NO.
215-20-7817 | | 17. INFORMANT
Mr. David H. Martin Hagerstown Md. RFD #4 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) Terminal carcinoma
1830 DUE TO, OR AS A CONSEQUENCE OF Carcinoma of the ovary
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 4 mos.
(b)
(c)
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
1750 | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2/15 , 19 68 , to 6/24 , 19 68 that (I) (we) lost saw the deceased alive on 6/23 , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Thomas V Craig | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/24/68 | | |
| 22d. PHYSICIAN'S NAME (Type)
Thomas V Craig | | | | 22e. ADDRESS
247 N POTOMAC Hagerstown | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 26-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Cemetery Mt. Taber Lutheran Church | | 23d. LOCATION (City or Town) (County) (State)
Fairview Maryland | | | | |
| 24. FUNERAL DIRECTOR
Albert L. Leaf Williamsport Md. | | | | ADDRESS
Williamsport Md. | | 25a. REC'D BY REGISTRAR
JUN 27 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 115 (4)
30M REV. 1/68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|--|---|--|--|--|--|--|--------------------------------|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Lottie | | | Middle
See | | | Last
McConnell | | | 2a. DATE OF DEATH
June Month 19 Day 1968 Year | | | 2b. HOUR
9 32 AM | | |
| 3. SEX
Female | | | 4. RACE
White | | | 5. DATE OF BIRTH
12/17/00 | | | 6. AGE (In years last birthday)
67 YRS. | | | IF UNDER 1 YEAR
MONTHS DAYS | | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country)
West Virginia | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital)
WESTERN MD. STATE HOSPITAL | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Worked in factory | | | 12b. KIND OF BUSINESS OR INDUSTRY
shoe | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Washington | | | 13c. CITY OR TOWN
Hagerstown | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET AND NUMBER
Hebb Rd. - Rt. #3 | | | | | |
| 14. FATHER'S NAME
Scott | | | First
nmn | | | Middle
Barnes | | | 15. MOTHER'S MAIDEN NAME
Dolly | | | First
Virginia | | | Last
Rockwell | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO.
214-09-3043A | | | 17. INFORMANT
Mr. C.E. McConnell R #3 | | | Address
Hagerstown, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of the breast
DUE TO, OR AS A CONSEQUENCE OF:
(b) Carcinoma of the breast
DUE TO, OR AS A CONSEQUENCE OF:
(c) Carcinoma of the breast
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 174X
170X | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
unknown
4 yrs | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
Cerebral Embolism | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from February 19 1968 to June 19 1968 , that (I) (we) lost the deceased alive on June 19 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE
Fe U. Porciuncula M.D. | | | 22c. DATE SIGNED
6/19/68 | | | 22d. PHYSICIAN'S NAME (Type)
Fe U. Porciuncula, M.D. | | | 22e. ADDRESS
Western Md. State Hospital
1500 Pennsylvania Ave., Hagerstown, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | 23b. DATE
6/22/68 | | | 23c. NAME OF CEMETERY OR CREMATORY
Rest Haven Cemetery | | | 23d. LOCATION (City or Town) (County) (State)
Hagerstown-Washington-Md. | | | | | | | | |
| 24. FUNERAL DIRECTOR
Wm. C. Horst | | | 24b. ADDRESS
Rest Haven Funeral Chapel Hagerstown, Md. | | | 25a. REC'D BY REGISTRAR
DATE JUN 21 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 2 and 3, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|---------------------------------------|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Moses C. McMurry | | | | 2a. DATE OF DEATH
Month June Day 21 Year 1968 | | | | 2b. HOUR
11:15 A.M. | | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Dec. 10, 1909 | | 6. AGE (in years
last birthday)
58 | | IF UNDER 1 YEAR
MONTHS YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) Liberal, Ka. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
WESTERN MD. STATE HOSPITAL | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Baker | | 12b. KIND OF BUSINESS OR
INDUSTRY
Bakery | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE Md. | | 13b. COUNTY
Allegany | | 13c. CITY OR TOWN
Cumberland | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
Jane Frazer Village | | | |
| 14. FATHER'S NAME First James Middle O. Last McMurry | | | | 15. MOTHER'S MAIDEN NAME First M. Bertha Middle Blank Last Blank | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) no (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
212-22-6599 | | 17. INFORMANT
Address Mrs. Vera Davis, Cumberland, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Bronchopneumonia
4369 DUE TO, OR AS A CONSEQUENCE OF CVA
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b)
DUE TO, OR AS A CONSEQUENCE OF (c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk
10 mon | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
331X Pulmonary infarct | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edwin G. Riley MD | | | | 22c. DATE SIGNED
21 June 1968 | | | | 22d. PHYSICIAN'S NAME (Type)
Edwin G. Riley MD | | | |
| 22e. ADDRESS
1500 Penn., Hagerstown, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
June 24, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Zion Memorial Park | | 23d. LOCATION (City or Town) (County) (State)
Cumberland, Allegany, Md. | | | | | |
| 24. FUNERAL DIRECTOR
ADDRESS
James F. Scarpelli, Cumberland, Md. | | | | 25a. REC'D BY REGISTRAR
DATE JUN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | |

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Memorandum
21 June 1968

MEMORANDUM

FOR THE RECORD

Branch of
CVA

Primary impact

Edmund G. Rife, MD
1200 Pennsylvania Avenue, NW
Washington, DC 20004
21 June 1968

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-333. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 09113 | | | | 09118 | | | |
| 1. DECEASED-NAME (Type or Print) Mary Leona Merriman | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month 6 Day 5 Year 1968 | | | |
| 3. SEX F. | | 4. RACE W. | | 5. DATE OF BIRTH 2/14/25 | | 6. AGE (In years last birthday) 43 | |
| 7a. BIRTHPLACE (State or foreign country) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH Washington | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Washington Co. Hosp. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland COUNTY Fredrick | | 13c. CITY OR TOWN Brunswick | | 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER 610 Second Ave. | |
| 14. FATHER'S NAME First Martin Middle Greenfield Last Greenfield | | | | 15. MOTHER'S MAIDEN NAME First Anna Middle Wenner Last Wenner | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO. unknown | | 17. INFORMANT Malinda L. Cook, Brunswick, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Lobular Pneumonia
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. 819.9
(b) Multiple Rib Fractures & Hemo-
DUE TO, OR AS A CONSEQUENCE OF
(c) pneumothorax - Fracture pelvis + tibia | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
3-5 days
10 days | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
8254 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY Month, Day, Year 6-22-68 HOUR A.M. P.M. | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) Auto Accident | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) Street | | 21f. LOCATION Street or R.F.D. No. Charles town City or Town Jess. County W.Va. State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE Edward W. Ditto III | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | 22b. DATE SIGNED 6-5-68 | |
| EXAMINER'S NAME (Type) Dr. Edward W. Ditto III | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | ADDRESS (Street, city, town, or county) 217 West Washington St. Hagerstown, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE 6/5/68 | | 23c. NAME OF CEMETERY OR CREMATORY Park Heights Cemetery | | 23d. LOCATION (City or town) Brunswick, Md. (County) W.Va. (State) | |
| 24. FUNERAL DIRECTOR Feete Funeral Home ADDRESS Brunswick, Md. | | | | 25a. REC'D BY REGISTRAR JUN 11 1968 DATE | | 25b. REGISTRAR'S SIGNATURE J. Charles Judge | |

8 11 8

UNITED STATES DEPARTMENT OF AGRICULTURE

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Health Department. Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

09114

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09119

| | | | | | | | | | |
|--|-------------------------|--|---|--|---|--|---|---|---------------------|
| 1. DECEASED-NAME
(Type or Print) | | | First
Marshall | Middle
Eugene | Lost
Monroe | 2a. DATE KNOWN OF DEATH
MATED <input checked="" type="checkbox"/> 6 15 1968 | | | 2b. HOUR
5:25 PM |
| 3. SEX
Male | 4. RACE
Negro | 5. DATE OF BIRTH
Nov. 2, 1940 | 6. AGE (In years last birthday)
27 YRS. | IF UNDER 1 YEAR
MONTHS 7 DAYS 13 | IF UNDER 24 HRS.
HOURS 13 MIN. | 2c. DATE PRONOUNCED DEAD
Month 6 Day 15 Year 1968 | | | 2d. HOUR
8:15 AM |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington | | | Md. |
| 10. CITY OR TOWN OF DEATH
Near Sharpsburg | | | 11. NAME OF HOSPITAL OR INSTITUTION Where in hospital give street address
POTOMAC RIVER at Shepherdstown Bridge | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Carpenter | | 12b. KIND OF BUSINESS OR INDUSTRY
Building | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Sharpsburg | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
227 W. Antietam St. | |
| 14. FATHER'S NAME
First Clarence Middle H. Monroe Lost | | | 15. MOTHER'S MAIDEN NAME
First Frances Middle M. Lost King | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No (If yes give war or dates of service) | | | |
| 16b. SOCIAL SECURITY NO.
218-38-1606 | | | 17. INFORMANT
227 W. Antietam St. Mr. Clarence H. Monroe Sharpsburg, Maryland | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Asphyxiation Due to Drowning
9:10:00
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b)
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
0-5 Min | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
9298 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
6-15-68 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Drowned while swimming in River | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Potomac River | | 21f. LOCATION Street or R.F.D. No.
River Near Shepherdstown | | City or Town
W.C. | | County
W.C. | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE
E. W. DITTO, III | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED
6-15-68 | | | |
| EXAMINER'S NAME (Type)
DR. E. W. DITTO, III | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | |
| | | | ADDRESS (Street, city, town, or county)
217 W. WASHINGTON ST., HAGERSTOWN, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Tolson Chapel Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Sharpsburg, Washington, Md. | | | |
| 24. FUNERAL DIRECTOR
Albert L. Leaf | | | ADDRESS
Williamsport, Maryland. | | | 25a. REC'D BY REGISTRAR
JUN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | |

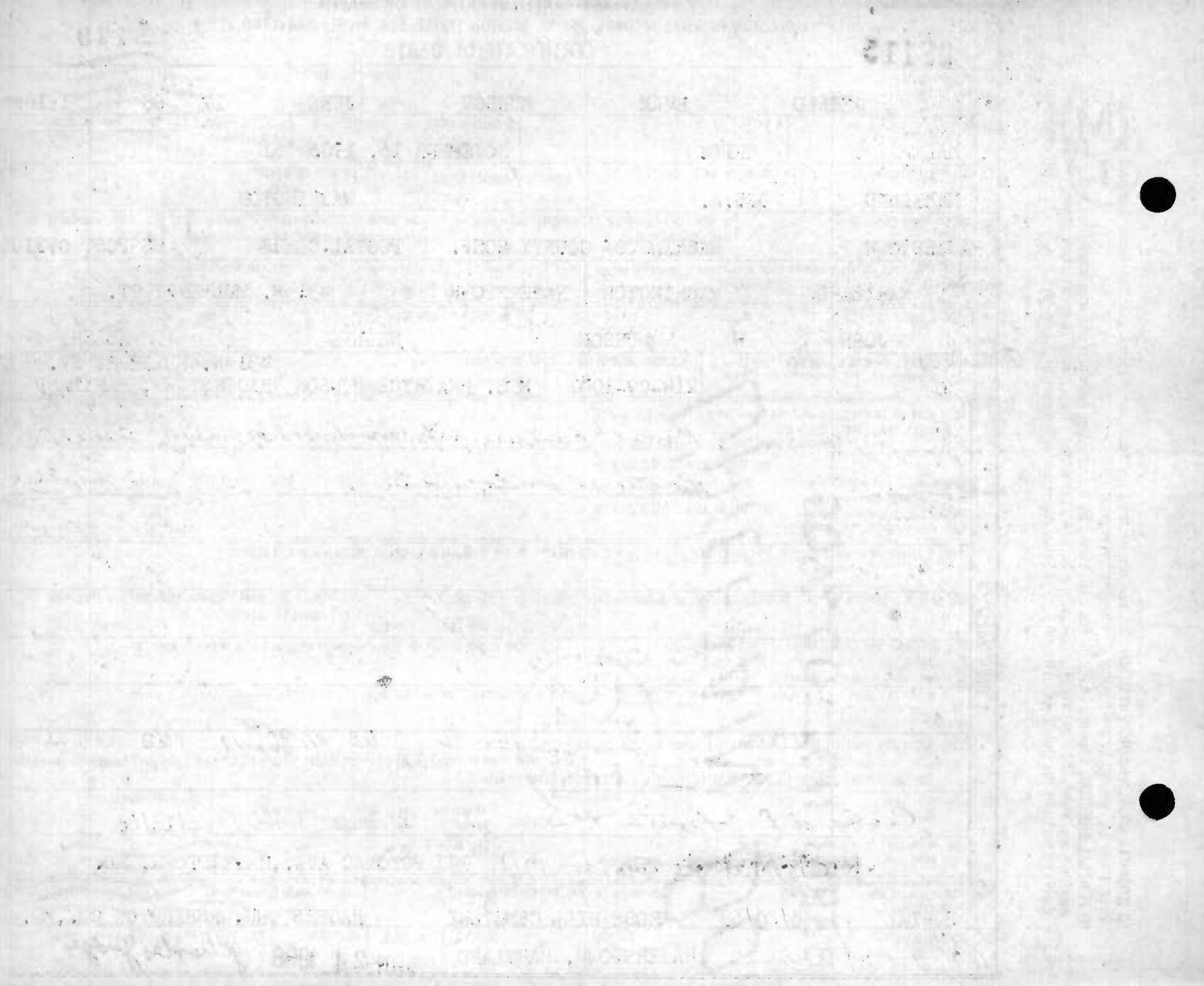
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers—pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 131 (3-64)
30M REV. 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
CERTIFICATE OF DEATH

| | | | | | | | | | | | | | |
|---|--|--|--|---|--|---|---|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print)
GERALD EVAN MUNSON | | | 2a. DATE OF DEATH
Month 17 Day 68 Year
JUNE | | | 2b. HOUR
1:10 PM | | | | | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
NOVEMBER 16, 1906 | | 6. AGE (In years last birthday)
61 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | | | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON COUNTY HOSP. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
POSTAL CLERK | | | 12b. KIND OF BUSINESS OR INDUSTRY
US POST OFFICE | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
431 N. MULBERRY ST. | | | | |
| 14. FATHER'S NAME
First JOHN Middle W Last MUNSON | | | 15. MOTHER'S MAIDEN NAME
First NELLIE Middle WELSH Last WELSH | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) NO (If yes give war or dates of service) | | | | 16b. SOCIAL SECURITY NO.
214-09-1081 | | 17. INFORMANT
MRS. BEATRICE MUNSON Address 431 N. MULBERRY ST. HAGERSTOWN, MARYLAND | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Renal failure, + Subarachnoid hemorrhage
421.0
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) Bacterial endocarditis
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
2 weeks
2 months | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)
4300 | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from June 6, 1968 , to June 17, 1968 , that (I) (we) saw the deceased alive on June 9, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Richard E. Smith M.D. DEGREE | | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/18/68 | | | | | |
| 22d. PHYSICIAN'S NAME (Type)
RICHARD E. Smith, MD | | | | | | 22e. ADDRESS
998 POTOMAC AVE., HAGERSTOWN, MD. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | 23b. DATE
6/20/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEMETERY | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN, WASHINGTON CO., MD. | | 24. FUNERAL DIRECTOR
Charles McKean ADDRESS
HAGERSTOWN, MARYLAND | | | | | |
| 25a. REC'D BY REGISTRAR
Charles Judge | | | | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | DATE
JUN 24 1968 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove 'cardboard' pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|---|--------------------------|---|--|---|--|------------------------|-------------------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | | Middle | | Last | | 2a. DATE OF DEATH
Month Day Year | |
| LEO | | | PAVLOV | | NAZARITI | | JUNE 25 1968 | | 7 A M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years
lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| MALE | | WHITE | | JUNE 5 1900 | | | 68 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | |
| RUSSIA | | U.S.A. | | | | WASHINGTON Md. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address) | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR
INDUSTRY | | | | |
| HAGERSTOWN | | WASHINGTON COUNTY HOSP. | | PHOTOGRAPHER | | PHOTO | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| N.Y. | | NEW YORK | | NEW YORK | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 605 W 142ND STREET | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | | |
| PAVLOV | | | NAZARITI | | | MARIA (UNKNOWN) | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no or unknown | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | |
| NO | | | 082-09-1727A | | MRS ARTEMIS NAZARITI | | 605 W 142ND ST N.Y. NY | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Ventricular Fibrillation</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Acute Myocardial Infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Arteriosclerotic Heart Disease</u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>instantaneous</u>
<u>5 wks</u>
<u>8 yrs</u> | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4201 | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>May 20, 1968</u> to <u>June 25, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 24, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | 22c. DATE SIGNED | | 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | |
| <u>Edson B Moody</u> | | 6/25/68 | | EDSON B MOODY M.D. | | 363 S. CLEVELAND AVE HAGERSTOWN MD. | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) | | (County) (State) | | |
| REMOVAL | | 6/26/68 | | JAREMA FUNERAL HOME | | NEW YORK | | N.Y. N.Y. | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| <u>Charles R. Judge</u> | | HAGERSTOWN MARYLAND | | JUN 28 1968 | | <u>Charles Judge</u> | | | | |

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OFFICE OF THE SECRETARY OF THE ARMY
WASHINGTON, D. C.
1947

MEMORANDUM FOR THE SECRETARY OF THE ARMY
SUBJECT: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

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10. [Illegible]

11. [Illegible]

12. [Illegible]

13. [Illegible]

14. [Illegible]

15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

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94. [Illegible]

95. [Illegible]

96. [Illegible]

97. [Illegible]

98. [Illegible]

99. [Illegible]

100. [Illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR 1534
30M REV. 1-68

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|---------|--|---|---|---|--|---|---|--------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Paul Melvin Paden | | | | | | June 30, 1968 | | | 7:15P ^M |
| 3. SEX | 4. RACE | | 5. DATE OF BIRTH | | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | White | | Jan. 6, 1905 | | | 63 YRS. | | 5 24 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Hagerstown | | U. S. A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | Washington Co. Hospital | | | Inspector | | Metal Mfg. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Hagerstown | | | | 836 Guildford Ave. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | |
| William Paden | | | Daisy Trovinger | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | 214-09-6131 | | Mrs. Mary L. Paden, 836 Guildford Ave. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>4 mos.</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Septicemia</u>
DUE TO, OR AS A CONSEQUENCE OF (b) <u>4 mos.</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a) | | | | | | | | | |
| MEDICAL CERTIFICATION | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <u>Yes</u> | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Apr. 1, 1968</u> , to <u>June 30, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 30, 1968</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED | |
| W.C. Brewer, M.D. | | M.D. | | PHYS. | | | | 7/6/68 | |
| 22d. PHYSICIAN'S NAME (Type) | | 22e. ADDRESS | | | | | | | |
| W.C. Brewer, M.D. | | Greenwood, P. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 7- 3- 68 | | Boonsboro Cemetery | | Boonsboro, Wash. Co., Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | | | JUL - 9 1968 | | Charles Judge | | | |

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Item 18 Film 403 8-19-66 MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

| | | | | | | | |
|---|-------------------------|--|---|--|--------------------------------|--|--|
| 1. DECEASED-NAME
(Type or Print) Anna Blanch Panos | | First Middle Last | | 2a. DATE KNOWN OF DEATH MATED <input type="checkbox"/> Month Day Year 6 8 1966 | | 2b. HOUR 11:30 PM | |
| 3. SEX
female | 4. RACE
white | 5. DATE OF BIRTH
4-5-1903 | 6. AGE (In years last birthday)
63 YRS. | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD
Month Day Year 6 9 1966 | |
| 7a. BIRTHPLACE (State or foreign country) Virginia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
518 Ridge St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Folder | | 12b. KIND OF BUSINESS OR INDUSTRY
Box Mfg. | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Ohio | | 13b. COUNTY Lucas | | 13c. CITY OR TOWN
Toledo | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME
Joseph Shifflett | | First Middle Last | | 15. MOTHER'S MAIDEN NAME
Margaret Moore | | First Middle Last | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) no | | 16b. SOCIAL SECURITY NO.
- - | | 17. INFORMANT
Mrs. Edward Moses, Toledo, Ohio | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Intoxication 1 POUND 1/4 11/1 & combined
DUE TO, OR AS A CONSEQUENCE OF
(b) effects of Librium & short action barbiturate
DUE TO, OR AS A CONSEQUENCE OF
(c)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
322.2 | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | | | | | | |
| ACTUAL SIGNATURE
Edward W. Ditto III | | EXAMINER'S NAME (Type)
DR. E.W. DITTO III | | M.D.
217 W. WASHINGTON ST. HAG. MD. | | 22b. DATE SIGNED
6-9-68 | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-12-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Forrest Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Toledo, Ohio | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home Hagerstown, Md. | | | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 11 1968 | |
| 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

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Anna Black Pinner

Female White 4-5-1903 65

Virginia USA

Logansport

213 Ridge St.

Ohio

Lucas Toledo

1328 Sherman

Joseph Shilfret

Mr. Edward Moser, Toledo, Ohio

DR. E. W. DITTO III

217 W. WASHINGTON ST. HAZ. MO.

6-12-68

Forest Cemetery

Toledo, Ohio

Union Funeral Home Hazlet, Mo.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon paper and pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|--|--|--|---|--|---|----------------------|--|---|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) ERIN ^{First} LOUISE ^{Middle} POPE ^{Last} | | | | | 2a. DATE OF DEATH
JUNE Month 20 Day 1968 | | 2b. HOUR
M | | |
| 3. SEX
FEMALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
2/1/1913 | | 6. AGE (In years lost birthday)
55 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
MISSOURI | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON | | Md. | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
1230 SALEM AVE. | | 12a. USUAL OCCUPATION (Kind of work done during last week or last 12 months)
SCHOOL TEACHER | | 12b. KIND OF BUSINESS OR INDUSTRY
PUBLIC SCHOOL | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
1230 SALEM AVE. | |
| 14. FATHER'S NAME ^{First} HENRY ^{Middle} F. ^{Last} McCULLOUGH | | | 15. MOTHER'S MAIDEN NAME ^{First} MARIE ^{Middle} WILSON ^{Last} | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or (unknown)
NO | | 16b. SOCIAL SECURITY NO.
515-12-3912 | | 17. INFORMANT Address
MR. MERRITT POPE HAGERSTOWN MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 4120 Vascular accident probably Myocardial infarct
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Arteriosclerotic heart disease and Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
minutes? indefinite | | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
4201 |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from never 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____ 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. Seen in absence of Dr. Bayer | | | | | | | | | |
| 22b. SIGNATURE
Robert F. Keadle | | DEGREE
MD. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | |
| 22d. PHYSICIAN'S NAME (Type)
Robert F. Keadle | | 22e. ADDRESS
580 Northern Ave., Hagerstown, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE
6/24/68 | | 23c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEM. | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | |
| 24. FUNERAL DIRECTOR
W.J. Norment, Hagerstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
DATE JUN 25 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARTIN LUTHER KING, JR. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|--------------------------------|--|
| 09120 | | | | | | | | | | | |
| 09125 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | First
ETHEL | | Middle
LENOR | | Last
PRESTON | | 2a. DATE OF DEATH
Month June Day 20 Year 1968 | | 2b. HOUR
M | |
| 3. SEX
Female | | 4. RACE
White | | 5. DATE OF BIRTH
Oct. 15 1900 | | 6. AGE (In years
last birthday)
67 YRS. | | IF UNDER 1 YEAR
MONTHS 8 DAYS 4 | | IF UNDER 24 HRS.
HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign
country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
Williamsport | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital
give street address)
29 E. Salisbury St. | | | | 12a. USUAL OCCUPATION (Kind of work done
during most of working life, even if retired.)
Housewife | | 12b. KIND OF BUSINESS OR
INDUSTRY
Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before
admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Williamsport | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
29 E. Salisbury St. | | | |
| 14. FATHER'S NAME
First Charles Middle Bramble Last Bramble | | 15. MOTHER'S MAIDEN NAME
First Nellie Middle Long Last Long | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown) No
(If yes give war or dates of service) ----- | | 16b. SOCIAL SECURITY NO.
216-07-1209 | | 17. INFORMANT
Mr. Isaac Preston 29 E. Salisbury St. Williamsport Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 402X Cardiac arrest
DUE TO, OR AS A CONSEQUENCE OF
(b) Multiple cardiac arrhythmia
DUE TO, OR AS A CONSEQUENCE OF
(c) Long term Hypertensive disease
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
< 5 mins
2 yrs
50 yrs | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
443X none | | | | | | | | | | | |
| 19a. DATE OF OPERATION
6-12-68 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
endometrial Sarcoma | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING
CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY,
OFFICE-BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 59 , to 6-20 , 19 68 , that (I) (we) last saw the deceased alive on 6-18-1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
M.E. Byrkit | | 22c. DATE SIGNED
6-20-68 | | 22d. PHYSICIAN'S NAME (Type)
M.E. Byrkit M.D. | | | | | | | |
| 22e. ADDRESS
20 West Potomac St. Williamsport, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION,
REMOVAL (Specify)
Burial | | 23b. DATE
June 22-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Greenlawn Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Williamsport Washington Md | | | | | |
| 24. FUNERAL DIRECTOR
Jennie E. Leaf Williamsport Maryland | | 25a. REC'D BY REGISTRAR
DATE JUN 21 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | | | | |

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TELEPHONE IN DEPT.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | |
|---|--|---|---|---|---|--|
| 1. DECEASED-NAME
(Type or print)
John Arthur Randall | | | 2a. DATE OF DEATH
June 9, 1968 | | 2b. HOUR
9:30A M | |
| 3. SEX
Male | 4. RACE
White | 5. DATE OF BIRTH
July 25, 1881 | | 6. AGE (In years last birthday)
88 YRS. | IF UNDER 1 YEAR
MONTHS DAYS
10 14 | IF UNDER 24 HRS.
HOURS MIN
10 14 |
| 7a. BIRTHPLACE (State or foreign country)
Durham, Maine | 7b. CITIZEN OF WHAT COUNTRY?
U. S. A. | 8. MARRIED
WIDOWED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Boonsboro | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Famney-Keedy Mem. Home | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Educator | 12b. KIND OF BUSINESS OR INDUSTRY
Education | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE
Maryland | 13b. COUNTY
Washington | 13c. CITY OR TOWN
Keedysville | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET AND NUMBER
Rfd. 1 | | |
| 14. FATHER'S NAME
First Middle Last
Greenfield A. Randall | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Julia Penley | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No. | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address
Mrs. Georgiana Randall, Rfd. 2, Boonsboro, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Atherosclerotic cardiac Wandering Disease</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <u>Pneumonia</u>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs
1 wk | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
4221 | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | |
| 22a. I certify that (I) (this hospital) attended the deceased from March 10, 1968, to June 9, 1968, that (I) (we) last saw the deceased alive on June 5, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | |
| 22b. SIGNATURE
G. W. Levan M.D. | | 22c. DATE SIGNED
6/10/68 | | 22d. PHYSICIAN'S NAME (Type)
G. W. Levan M.D. | | |
| 22e. ADDRESS
Boonsboro, Md. | | 22f. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Cremation | | 23b. DATE
6-11-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Fort Lincoln Crematory | | |
| 23d. LOCATION (City or Town)
3201 Bladensburg Rd. Wash. D.C. | | 23e. (County) (State) | | | | |
| 24. FUNERAL DIRECTOR
John H. Bast, Jr. 112 N. Main St. Boonsboro, Md. | | 25a. REC'D BY REGISTRAR
JUN 12 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judgen | | |

1912

EXHIBIT OF DEATH

1912

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

John

FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form P-13. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| MIDDLE | | | | | | | | | | | | LAST | | FIRST | | MIDDLE | | LAST | |
|--|--|---------|--|--|--|---------------------------------|--|---|--|------------------|--|--|--|---|--|--------------------|--|--------|--|
| 1. DECEASED-NAME (Type or Print) | | | | | | | | | | | | REESER | | DENNIS | | EUGENE | | REESER | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | | 7a. DATE KNOWN OF DEATH | | 8. MARRIED | | 9. COUNTY OF DEATH | | | |
| Male | | White | | April 30-51 | | 17 YRS. | | MONTHS 1 | | DAYS 9 | | Month 6 Day 9 Year 1968 | | NEVER MARRIED <input checked="" type="checkbox"/> | | Washington | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8. MARRIED | | | | 9. COUNTY OF DEATH | | | | | | | |
| Maryland | | | | U.S.A. | | | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | Washington | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| Near Charleoten, Md. | | | | Potomac River | | | | Laborer | | | | Brick Yard | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | 13b. COUNTY | | | | 13c. INSIDE CITY LIMITS? | | | | 13e. STREET AND NUMBER | | | | | | | |
| Maryland | | | | Washington | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | Williamsport, Md. RFD #2 | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? | | | | 16b. SOCIAL SECURITY NO. | | | | | | | |
| Briscoe | | | | Dorothy | | | | No | | | | 214-54-0237 | | | | | | | |
| 17. INFORMANT | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | 19. DATE OF OPERATION | | | | 20. AUTOPSY? | | | | | | | |
| Pinesburg #2 | | | | PART I. DEATH WAS CAUSED BY: | | | | 910.0 | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| Williamsport Md RFD | | | | IMMEDIATE CAUSE (a) | | | | Asphyxiation Due to | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| | | | | (b) | | | | Drowning | | | | 0-5 Min | | | | | | | |
| | | | | (c) | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | | | | | | |
| 9298 | | | | | | | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | 21d. INJURY OCCURRED | | | | | | | |
| | | | | 1:40 P.M. 6-9 1968 | | | | Drowned in Potomac River | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | | | | |
| 21f. LOCATION Street or R.F.D. No. | | | | 21g. LOCATION City or Town | | | | 21h. LOCATION County | | | | 21i. LOCATION State | | | | | | | |
| Nr. Charleston | | | | Washington | | | | Md | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | CHIEF MEDICAL EXAMINER | | | | 22b. DATE SIGNED | | | | | | | | | | | |
| EXAMINER'S NAME (Type) | | | | DEPUTY MEDICAL EXAMINER | | | | 6-9-68 | | | | | | | | | | | |
| Edward W. Ditto III | | | | Hagerstown, Md. Wash. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | |
| Burial | | | | June 12-68 | | | | Greenlawn Cemetery | | | | Williamsport Md. | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | 25a. REC'D BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | |
| Albert L. Leaf Williamsport Md. | | | | DATE JUN 11 1968 | | | | Charles Judge | | | | | | | | | | | |

28:20

FOR STATE HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|---------|---|--|--|---|---|---|---|--|
| 09123 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 09128 | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. HOUR |
| RICHARD LEWIS REPP | | | | | | DATE MATED <input checked="" type="checkbox"/> 6 10 1968 | | | 7:28 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS
HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | |
| MALE | WHITE | AUG. 6, 1939 | 28 YRS. | | | | | Month JUNE Day 10 Year 1968 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| MARYLAND | | U.S.A. | | | | WASHINGTON, Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | 12b. KIND OF BUSINESS OR INDUSTRY |
| RURAL HAGERSTOWN | | | ----- | | | BRICK MASON | | | HOME BLDG. |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET AND NUMBER |
| MARYLAND | | | WASHINGTON | | HAGERSTOWN | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | SHARPSBURG PIKE |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| RICHARD CLAYTON REPP | | | MARGARET SPRECHER | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | |
| NO | | | 212-38-9501 | | RT #2 ADDRESS MR. RICHARD C. REPP HAGERSTOWN, MARYLAND | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound to</u> | | | | | | | | | |
| 955X DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Head</u> | | | | | | | | | Timed |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 976X | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | 7:28 AM 6-10-1968 | | Self inflicted gunshot wound | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County | State |
| Home | | Home | | Rt #3 | | Hagerstown | | Wash | Md |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | M.D. | | | JUNE 11, 1968 | | | |
| E.W. DITTO, 3rd. M.D. | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | 217 W. WASH ST. HAGERSTOWN, MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | |
| BURIAL | | | 6/12/68 | | CEDAR LAWN MEMORIAL PARK | | WASHINGTON COUNTY, MARYLAND | | |
| 24. FUNERAL DIRECTOR | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Charles M. Royce | | | | | HAGERSTOWN, MARYLAND | | DATE JUN 14 1968 | | Charles J. Jager |

53-25

1
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be procured within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--------|---|--|---|--|---|--------|---|--|
| 1. DECEASED-NAME
(Type or print) | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR | | | | |
| David | | M. | | Ridenour | June 15 1968 | | 8 a.m. | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN. | |
| Male | | White | | Sept. 25, 1878 | | 89 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | | |
| Maryland | | U.S.A. | | | | Washington | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| R. D. 3, Smithsburg | | - - - | | Farmer | | Farm | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | | |
| Maryland | | Washington | | Smithsburg | | | | R. D. 3 | | | |
| 14. FATHER'S NAME | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | First | Middle | Last | | |
| Levi | | | | Ridenour | Malinda | | | | Stephy | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, (no, or unknown) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | Address | | | | | |
| | | 215-366947A | | Mrs. George M. Rowe | | Smithsburg #3, Maryland | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>4129</u> <u>Leakage of Thrombosis</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Myocardial Insufficiency</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Thrombotic Cerebral Sclerosis</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>3 Day</u>
<u>1 hr</u>
<u>2 c</u> | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>4221</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>June 13, 1968</u> to <u>June 15, 1968</u> , that (I) (we) last saw the deceased alive on <u>June 15, 1968</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Geo G Kohler MD</u> | | DEGREE | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>June 17 1968</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Geo A Kohler</u> | | 22e. ADDRESS
<u>Smithsburg Md</u> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Entombment</u> | | 23b. DATE
<u>6/18/1968</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Smithsburg Mausoleum</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Smithsburg, Washington, Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>Walter Y Shore</u> | | ADDRESS
<u>Waynesboro, Penna.</u> | | 25a. REC'D BY REGISTRAR
<u>June 19 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Walter Y Shore</u> | | | | | |

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Figure 2

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FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with funeral home's copy. 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

Items 18, 22a film 401 Maryland State Department of Health
7-1-68 mt. DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201
Item 5&6, Film 401 6/2 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

09125 09130

| | | | | | | | | | | | |
|--|--|--|---|--|--|---|--|---|--|--|--|
| 1. DECEASED-NAME
(Type or Print) Lloyd Douglas Sales | | | 2a. DATE KNOWN OF DEATH <input type="checkbox"/> Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year June 14, 1968 | | | 2b. HOUR 3 A.M. | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH February 3, 1921 | | 6. AGE (In years last birthday) 47 YRS. | | 7. IF UNDER 1 YEAR
MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH Washington, Md. | | | 2c. DATE PRONOUNCED DEAD
Month June Day 14 , Year 1968 | | |
| 10. CITY OR TOWN OF DEATH Hagerstown | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) 820 Concord St. | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Attendant | | | 12b. KIND OF BUSINESS OR INDUSTRY Gas Station | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland | | | 13b. CITY OR TOWN Washington | | | 13c. CITY OR TOWN Hagerstown | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | 13e. STREET AND NUMBER 820 Concord Street | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) Yes | | | 16b. SOCIAL SECURITY NO. W.W.2 230-09-7239 | | | 17. INFORMANT Mrs. Orphia Ebersole ADDRESS 820 Concord St. Hagerstown, Maryland. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 3039 Pending/ Acute Alcoholism with
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) probable Aspiration of Vomitus
DUE TO, OR AS A CONSEQUENCE OF
(c) 3220 | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Few minutes | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY Month, Day, Year 19 HOUR A.M. P.M. | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Port 2, Item 18.) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Dr. E. W. Ditto, Jr. M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED June 17, 1968 | | | |
| EXAMINER'S NAME (Type) Dr. E. W. Ditto, Jr. | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | ADDRESS (Street, city, town, or county) Hagerstown, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | 23b. DATE June 17/68 | | | | 23c. NAME OF CEMETERY OR CREMATORY Rose Hill Cemetery | | | |
| 23d. LOCATION (City or Town) Hagerstown, Maryland. | | | | 23e. LOCATION (City or Town) (County) (State) | | | | | | | |
| 24. FUNERAL DIRECTOR Hagerstown, Md. Andrew Coffman Funeral Home Inc. | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE Charles Judge | | | |
| DATE JUN 20 1968 | | | | | | | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|--|--|---|--|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First WILLIAM Middle JOHN Last SCHEELEY | | | | | 2a. DATE OF DEATH
JUNE Month 5 Day 1968 Year | | | 2b. HOUR
1 P | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
1/13/1886 | | 6. AGE (In years last birthday)
82 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign)
PENNSYLVANIA | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give then address)
FAHRNEY KEEDY MEN. HOME | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)
RETIRED ENGINEER | | 12b. KIND OF BUSINESS OR INDUSTRY
RAIL ROAD | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
SAN MAR | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
RURAL BOONSBORO | |
| 14. FATHER'S NAME
First MATHEW Middle SCHEELEY Last | | 15. MOTHER'S MAIDEN NAME
First CATHERINE Middle KILGUS Last | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, No or Unknown) NO | | 16b. SOCIAL SECURITY NO.
707-16-7096 | | 17. INFORMANT
MR. WILLIAM L. SCHEELEY | | Address HAGERSTOWN MD. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Acute pneumonia
DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
10 yrs
1 wk |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 10, 1968 , to June 5, 1968 , that (I) (we) last saw the deceased alive on June 5, 1968 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
G. W. Lelton M.D. | | DEGREE
G. W. Lelton M.D. | | ATTENDING PHYS.
<input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE, SIGNED
6/7/68 | | | |
| 22d. PHYSICIAN'S NAME (Type)
G. W. Lelton M.D. | | 22e. ADDRESS
Boonsboro, Md | | | | | | | |
| 23a. BURIAL, CREMATION, or other disposition
BURIAL | | 23b. DATE
6/8/68 | | 23c. NAME OF CEMETERY OR CREMATORY
REST HAVEN CEM. | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | |
| 24. FUNERAL DIRECTOR
W. T. Norman, Hagerstown, Md. | | ADDRESS | | 25a. REC'D BY REGISTRAR
JUN 12 1968 | | 25b. REGISTRAR'S SIGNATURE
[Signature] | | | |

05120

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3 (Page 5 may be retained for your files).

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in only event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | |
|--|--|-------------------------|---|-------------------------------------|--|--|--|--|---|--|---|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
WILLIAM | | | Middle
EDWARD | | | Last
SHAFFER | | | |
| 3. SEX
MALE | | 4. RACE
WHITE | | 5. DATE OF BIRTH
9/6/1901 | | 6. AGE (in years last birthday)
66 YRS. | | IF UNDER 1 YEAR
MONTHS
0 DAYS
0 | | IF UNDER 24 HRS
HOURS
0 MIN.
0 | | |
| 7a. BIRTHPLACE (State or foreign country)
MARYLAND | | | 7b. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | 8. MARRIED
<input checked="" type="checkbox"/> NEVER MARRIED
<input type="checkbox"/> WIDOWED
<input type="checkbox"/> DIVORCED | | 9. COUNTY OF DEATH
WASHINGTON | | | 2a. DATE KNOWN OF DEATH
Month JUNE Day 23 Year 68 | |
| 10. CITY OR TOWN OF DEATH
HAGERSTOWN | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
WASHINGTON COUNTY HOSPITAL | | | | 12a. USUAL OCCUPATION (If retired, state during most of working life, even if retired.)
PLUMBER | | | 2b. HOUR
3:35 a.m. | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
MARYLAND | | | 13b. COUNTY
WASHINGTON | | 13c. CITY OR TOWN
HAGERSTOWN | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
225 S. POTOMAC ST. | | | |
| 14. FATHER'S NAME
First WILLIAM Middle HENRY H. Last SHAFFER | | | | | 15. MOTHER'S MAIDEN NAME
First PHIANNA Middle RHODES Last RHODES | | | | | 16b. SOCIAL SECURITY NO.
214-09-2198A | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
NO | | | | | 17. INFORMANT
MR. GEARID ALEXANDER | | | | | ADDRESS HAGERSTOWN MD. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4129 IMMEDIATE CAUSE (a) Congestive failure
DUE TO, OR AS A CONSEQUENCE OF Arteriosclerotic cardiovascular disease
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4221
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Tbc.--active., Fracture of right hip., Chronic alcoholism. | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY Month, Day, Year
6/10/68
HOUR A.M. 9:30 P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
Fall on Baltimore Street | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
Baltimore St. | | 21f. LOCATION Street or R.F.D. No. City or Town County State
Baltimore St. Hagerstown Wash. Md. | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | |
| ACTUAL SIGNATURE
Howard N. Weeks | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | | 22b. DATE SIGNED 6/24/68 | | |
| EXAMINER'S NAME (Type)
Howard N. Weeks, M. D. | | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | | | ADDRESS (Street, city, town, or county)
580 Northern Avenue, Hagerstown, Md. | | |
| 23a. BURIAL CREMATION REMOVAL
BURIAL | | | 23b. DATE
6/25/68 | | 23c. NAME OF CEMETERY OR CREMATORY
ROSE HILL CEM. | | | 23d. LOCATION (City or Town) (County) (State)
HAGERSTOWN WASH. MD. | | | | |
| 24. FUNERAL DIRECTOR
W. J. Norment, Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 26 1968 | | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | | | | |

0525

88 FORN AND LITTON, 1998

REF ID: A6212-20-11

James M. Cox

638 J. S. HUI

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|---|--|--|--|---|--|---|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH | | 2b. HOUR | |
| Henry | | | Jacob | | | June 29 1968 | | 3:00P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Male | | White | | Nov. 2, 1881 | | 66 YRS. | | 7 27 | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Fairplay, Md. | | U. S. A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Boonsboro | | | Fahrney- Keedy Mem. Home | | | Stock Clerk | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| Maryland | | | Frederick | | | Frederick | | 522 Trail Ave. | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| First Middle Last | | | First Middle Last | | | | | | |
| Jacob | | | Show | | | Eveline Hieghberger | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | |
| No. | | | 217-10-9763 | | | Fahrney- Keedy Home Records, Boonsboro, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Aplastic anemia</u>
284X DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>Pneumonitis</u>
(b) <u></u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>5 yrs</u>
<u>2 days</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>2924</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital), attended the deceased from <u>Sept 16, 1967</u> , to <u>June 29, 1968</u> , that (I) (<u>we</u>) last saw the deceased alive on <u>June 29, 1968</u> , and that in (my) (<u>our</u>) opinion death occurred on the date and hour and from the causes stated above, (I) (<u>we</u>) did (<u>did not</u>) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>G. W. LeVan</u> | | | | DEGREE
ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>July 1, 1968</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>G. W. LeVan</u> | | | | 22e. ADDRESS
<u>Boonsboro, Md.</u> | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>Burial</u> | | <u>7-2-68</u> | | <u>Fairview Cemetery</u> | | <u>Keedysville, Wash. Co., Md.</u> | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>John H. Bast, Jr. 112 N. Main St. Boonsboro, Md.</u> | | | | <u>JUL - 5 1968</u> | | <u>Charles Judge</u> | | | |

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09129

CERTIFICATE OF DEATH

| | | | | | | | | | | | |
|--|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED-NAME
(Type or print) <i>Philip</i> | | | First Middle Last | | | 2a. DATE OF DEATH
<i>June</i> Month Day <i>25</i> Year <i>1968</i> | | | 2b. HOUR
<i>6:20</i> A.M. | | |
| 3. SEX
<i>Male</i> | | | 4. RACE
<i>White</i> | | | 5. DATE OF BIRTH
<i>Jan 9, 1887</i> | | | 6. AGE (In years last birthday)
<i>81</i> YRS. | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Martinsburg W.Va.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>American</i> | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Washington</i> Md. | | |
| 10. CITY OR TOWN OF DEATH
<i>Williamsport</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Williamsport Sanitarium</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired)
<i>Machinist & tool maker</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Navy Yard</i> | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>West Va.</i> | | | 13b. COUNTY
<i>Berkeley</i> | | | 13c. CITY OR TOWN
<i>Hedgesville</i> | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 13e. STREET AND NUMBER
<i>R. 7. D #3</i> | | | 14. FATHER'S NAME
<i>George T</i> | | | 15. MOTHER'S MAIDEN NAME
<i>Nancy</i> | | | 16. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <i>No</i> | | |
| 16b. SOCIAL SECURITY NO.
<i>No</i> | | | 17. INFORMANT
<i>Mrs. Florence Showers - Hedgesville, West Va.</i> | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia</i>
<i>4270</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) <i>Congestive heart failure</i>
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>3 days</i>
<i>4 days</i> | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<i>4341</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>5-7-68</i> , 19 <i>68</i> , to <i>6-24</i> , 19 <i>68</i> , that (I) (we) saw the deceased alive on <i>6-24</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<i>M.E. Byrkit</i> | | | 22c. DATE SIGNED
<i>6-27-68</i> | | | 22d. PHYSICIAN'S NAME (Type) <i>M.E. Byrkit M.D.</i> | | | 22e. ADDRESS
<i>28 West Potomac St., Williamsport Md.</i> | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>June 27, 1968</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Green Hill Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Martinsburg, Berkeley, W. Va.</i> | | |
| 24. FUNERAL DIRECTOR
<i>Howard R. Brown</i> | | | 24b. ADDRESS
<i>W. Va.</i> | | | 25a. REC'D BY REGISTRAR
<i>JUL - 1 1968</i> | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

00132

RECEIVED

28

RECEIVED

X

RECEIVED

NO

NO

X

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1
2

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|---|--------------------------|-----------------------------|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
Charles | | Middle
Hamilton | | Last
Slick | | 2a. DATE OF DEATH
June 15 Day 1968 | | 2b. HOUR
M | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
April 14, 1889 | | | 6. AGE (In years last birthday)
79 YRS. | | IF UNDER 1 YEAR
MONTHS | | IF UNDER 24 HRS.
DAYS | | |
| 7a. BIRTHPLACE (State or foreign country)
Md. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
Washington Md. | | | | | | |
| 10. CITY OR TOWN OF DEATH
Smithsburg | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
47 N. Main Street | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Labor | | | 12b. KIND OF BUSINESS OR INDUSTRY
Shop | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Smithsburg | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
47 N. Main Street | | | | |
| 14. FATHER'S NAME
First Middle Last
William T. Slick | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
Annie - Masters | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
No | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service)
214-03-5704 | | 17. INFORMANT
Address
Mrs. Susan M. Slick, 24, N. Main St. Smithsburg, Md. | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Pulmonary Edema</u>
4129 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Coronary artery disease - 99 years</u>
1019
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
4221 | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
24 hrs
4 yrs | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5/20, 1968, to 6/15, 1968, that (I) (we) last saw the deceased alive on 6/15, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
Geo. A. Koller M.D. | | | | DEGREE
M.D. | | ATTENDING PHYS. <input checked="" type="checkbox"/> | | MED. DIRECTOR <input type="checkbox"/> | | STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6/17/68 | |
| 22d. PHYSICIAN'S NAME (Type)
Geo. A. Koller | | | | 22e. ADDRESS
Sanitizing | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
June 18, 1968 | | 23c. NAME OF CEMETERY OR CREMATORY
Cavetown Cemetery | | | | 23d. LOCATION (City or town) (County) (State)
Cavetown Washington Md. | | | | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home, Smithsburg, Md. | | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 18 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles J. ... | | | | | |

00130

OFFICE OF THE

00130



[Faint, illegible handwritten text and markings, possibly a signature or date, covering the lower half of the page.]

[Faint vertical text on the right margin, possibly a page number or reference.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|--|--|---|--|---|---|---|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Margaret Ruth Smith | | | | | 2a. DATE OF DEATH
Month June Day 18 Year 1968 | | | 2b. HOUR
8:25 P.M. | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
Nov. 23, 1896 | | 6. AGE (In years lost birthday)
71 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
Maryland | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Washington | | Md. | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
Wash. Co. Hospital | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
clerk | | 12b. KIND OF BUSINESS OR INDUSTRY
Dept. store | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Maryland | | 13b. COUNTY
Washington | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
21 Berner Ave. | |
| 14. FATHER'S NAME First Middle Last
Franklin D. Miner | | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Sarah E. Weaver | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> no <input checked="" type="checkbox"/> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address
John W. Smith, Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
4120 IMMEDIATE CAUSE (a) Cerebral hemorrhage, multiple
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Hypertensive cardiovascular disease
DUE TO, OR AS A CONSEQUENCE OF
(c) XXXXXXXXXXXXXXXXXXXX | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4 weeks

Unknown | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)
443X Diabetes mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 5-10-68 , 19____, to 6-16-68 , 19____, that (I) (we) last saw the deceased alive on 6-16-68 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<i>E. R. Lardizabal</i> | | | | | DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
June 18, 1968 | | |
| 22d. PHYSICIAN'S NAME (Type)
E. R. Lardizabal, M. D. | | | | | 22e. ADDRESS
300 N. Potomac St. Hagerstown, Md. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE
6-19-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Mt. View Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Ringgold, Md. | | | |
| 24. FUNERAL DIRECTOR ADDRESS
Minnich Funeral Home, Hagerstown, Md. | | | | | 25a. REC'D BY REGISTRAR
DATE JUN 20 1968 | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | |

26122

John T. Smith, Mayor, 1892

陳士英、王人強、李國興、吳文雄、謝文榮

Uitendaele, 2001)

100

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2, should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|------------------------------|--|---|------------------------------------|---|--|---|------------------------|--|------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Lloyd | | | Amos | Sponseller | Month Day Year
June 22 1968 | | | M | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | | | |
| Male | | White | | November 20, 1890 | | 77 YRS. | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | | | |
| Adams Co. Penna. | | USA | | | | Washington Md. | | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | | Washington County Hospital | | | Cabinet Maker | | Furniture | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | | |
| Maryland | | | Washington | | Beaver Creek | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | R # 1 Hagerstown | | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First | Middle | Last |
| Rufus | | | Samuel | Sponseller | Mandilla | Maria | | | Snyder | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT Address | | | | | |
| No | | | 214-09-6871 | | | Mrs. L.A. Sponseller R # 1 Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Myocardial Infarction due to Coronary | | | | | | | | | | 72 hrs | |
| 4100 CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause lost. 4201 | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerosis + Advanced Bilateral | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) Nephrosclerosis | | | | | | | | | | 5-10 yrs | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| Prostate hypertrophy, Benign Diverticulosis sigmoid colon | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from June 20, 1968, to June 22, 1968, that (I) (we) last saw the deceased alive on June 22, 1968 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
Edward W. Ditto, III | | | | | | DEGREE
ATTENDING PHYS. | | <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
6-24-68 | |
| 22d. PHYSICIAN'S NAME (Type)
Edward W. Ditto, III, M.D. | | | | | | 22e. ADDRESS
217 W. Wash. St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 6/25/68 | | Rest Haven Cemetery | | | Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR
Wm. G. Hoon | | | | | | ADDRESS
Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 26 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |
| Rest Haven Funeral Chapel | | | | | | | | | | | |

00133

Washington

1953

| Date | Place | Description | Amount |
|------|------------|----------------------------|--------|
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
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| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |
| 1953 | Washington | Washington County Hospital | 100.00 |

W. C. Hunt

Washington County Hospital
100.00

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Page 1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
|---|---------|--|--|--|---|---|--|--|--|
| 09138 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME (Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN OF DEATH | | | 2b. TIME |
| BEARNEDETTA JOHNSON SPRINGER | | | | | | ESTIMATED <input type="checkbox"/> MONTH DAY YEAR | | | June 1 19 68 8:40 PM |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | 2c. DATE PRONOUNCED DEAD | |
| Female | White | Feb. 1, 1879 | 89 YRS. | | | | | Month Day Year 19 68 4:40 PM | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| Maryland | | U.S.A. | | | | Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Hagerstown | | Washington County Hosp. | | | | House Work | | Own Home | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER |
| Maryland | | | Washington | | Hagerstown | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 1400 Virginia Ave. |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | |
| Vandell Johnson | | | Frances Brasgears | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | 16b. SOCIAL SECURITY NO. (If yes give year or dates of service) | | 17. INFORMANT | | | ADDRESS | | |
| No | | None | | Miss Dorothy Springer | | | 1400 Virginia Ave. Hagerstown Md | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | |
| IMMEDIATE CAUSE (a) Arteriosclerotic Cardio Vascular Disease | | | | | | | | | 10 years |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | |
| (b) Shock from Fractures Following Fall | | | | | | | | | 11 hours |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | |
| (c) Fracture Of Femur And Humerus | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 4221 | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | |
| | | | 6 P.M. 5-31- 1968 | | Fell while walking in her home. | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | |
| | | | Home | | 1400 Virginia Ave., Hagerstown, Washington, Md. | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | |
| ACTUAL SIGNATURE | | | CHIEF MEDICAL EXAMINER | | | 22b. DATE SIGNED | | | |
| EXAMINER'S NAME (Type) | | | ASSISTANT MEDICAL EXAMINER | | | June 1, 1968 | | | |
| Dr. E. W. Ditto, Jr. | | | DEPUTY MEDICAL EXAMINER | | | ADDRESS (Street, city, town, or county) | | | |
| | | | 215 W. Washington St., Hagerstown, Md. | | | | | | |
| 23a. BURIAL, CREMATION, OR OTHER (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6/4/1968 | | Rose Hill Cemetery | | Hagerstown, Wash. Maryland | | | |
| 24. FUNERAL DIRECTOR | | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| Funeral Andrew K. Coffman Home Inc/ Hagerstown, Maryland | | | | | | DATE JUN 4 1968 | | J. Charles Judge | |

1943

1943

June 1 1943

ANNETTE JOHNSON SPRINGER

Female White Feb. 1, 1913

June 1,

Washington

X

U.S.A.

Maryland

Hagerston

Washington County Hosp.

House 100

One Home

Maryland

Washington

Hagerston

X

1400 Virginia Ave.

Frances Hagerston

Yendell Johnson

None

Miss Dorothy Springer

1400 Virginia Ave.

Attention: Mr. and Mrs. Hagerston

Spokane Falls, Washington

Spokane Falls, Washington

Spokane Falls, Washington

1400 Virginia Ave., Hagerston, Washington

None

June 1, 1943

June 1, 1943

Miss Dorothy Springer

None

Spokane Falls

Spokane Falls

Spokane Falls, Washington

Spokane Falls, Washington

June 1, 1943

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--|---|--|--|--|--|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) Ada Marie Stottlemeyer | | | | | 2a. DATE OF DEATH
6 Month 30 Day 68 Year | | | 2b. HOUR
6:20 P.M. | |
| 3. SEX
female | | 4. RACE
white | | 5. DATE OF BIRTH
11-24-02 | | 6. AGE (In years last birthday)
65 YRS. | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (State or foreign country)
W. Va. | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. COUNTY OF DEATH
Washington Md. | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
306 S. Locust St. | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Inspector | | 12b. KIND OF BUSINESS OR INDUSTRY
Dress Mfg. | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Md. | | 13b. COUNTY
Wash. | | 13c. CITY OR TOWN
Hagerstown | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
306 S. Locust St. | |
| 14. FATHER'S NAME First Middle Last
John Ashby | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
Lennie Ashby | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes <input type="checkbox"/> No <input checked="" type="checkbox"/> or unknown | | 16b. SOCIAL SECURITY NO.
220-26-0034 | | 17. INFORMANT
Alice Hurd | | Address
Hagerstown, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION
4100 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4201
(b) HYPERTENSIVE-ARTERIOSCLEROTIC C.V. DISEASE
DUE TO, OR AS A CONSEQUENCE OF
(c)
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Seconds
Yes. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Chronic Constrictive Heart Failure - Diabetes Mellitus | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Nat while <input type="checkbox"/>
at work at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. | | City or Town | | County State | |
| 22a. I certify that (I) (this hospital) attended the deceased from March , 19 63 , to 30 June , 19 68 , that (I) (we) last saw the deceased alive on 24 June , 19 68 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
W.N. FENDER | | | | 22c. DATE SIGNED
1 July 1968 | | 22d. PHYSICIAN'S NAME (Type)
W.N. FENDER | | | |
| 22e. ADDRESS
218 N. Peromac St., Hagerstown, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
burial | | 23b. DATE
7-2-68 | | 23c. NAME OF CEMETERY OR CREMATORY
Evansville Cemetery | | 23d. LOCATION (City or Town) (County) (State)
Evansville, W. Va. | | | |
| 24. FUNERAL DIRECTOR
Minnich Funeral Home Hagerstown, Md. | | | | 25a. REC'D BY REGISTRAR
JUL - 8 1968 | | 25b. REGISTRAR'S SIGNATURE
J. Charles Judge | | | |

02134

DEPARTMENT OF STATE

1913

| | | | | | | |
|-------------|--------------------|------------|----------|-------|------------|----|
| John Asby | 1000 E. Locust St. | Washington | 11-24-12 | white | Scottsboro | 10 |
| Lennie Asby | 1000 E. Locust St. | Washington | 11-24-12 | white | Scottsboro | 10 |
| Alice Lund | 1000 E. Locust St. | Washington | 11-24-12 | white | Scottsboro | 10 |

[Faint, mostly illegible text in the middle section of the document, possibly containing names and addresses.]

7-2-58
 1000 E. Locust St.
 Washington, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|---|---|---|--|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Lost | | | 2a. DATE OF DEATH | | | 2b. HOUR |
| James | | | Garfield Testerman | | | June Month 28 Day 1968 Year | | | 12:01 |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years lost birthday) | | IF UNDER 1 YEAR
MONTHS DAYS HOURS MIN. | |
| Male | | White | | 9/10/90 | | 77 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | | |
| North Carolina | | USA | | | | WASHINGTON Md. | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| HAGERSTOWN | | WESTERN MD. STATE HOSPITAL | | cabinet maker | | Lumber | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Frederick | | Union Bridge | | | | Rt. 2 | |
| 14. FATHER'S NAME | | | First Middle Lost | | | 15. MOTHER'S MAIDEN NAME | | | First Middle Lost |
| Wilson | | | Testerman | | | Ruth Nancy J. Mock | | | Sprague |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown | | | 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT | | | Address |
| No | | | 218-32-9684 | | | Mrs. Marshall Testerman | | | Union Bridge, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>multiple pulmonary emboli with massive infarction</u> | | | | | | | | | 1 day |
| DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Carcinoma of prostate with metastases</u> | | | | | | | | | 9 yrs. |
| DUE TO, OR AS A CONSEQUENCE OF
(c) | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Cerebral vascular accident</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | yes | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>2/8</u> , 19 <u>68</u> , to <u>6/28</u> , 19 <u>68</u> , that (I) (we) saw the deceased alive on <u>6/27</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Domingo A. Garcia</u> | | | | | | DEGREE
ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22c. DATE SIGNED
<u>6/28/68</u> | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Domingo A. Garcia, M.D.</u> | | | | | | 22e. ADDRESS <u>Western Md. State Hospital</u>
<u>1500 Pa. Ave., Hagerstown, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| <u>Removal - Burial</u> | | <u>6-30-68</u> | | <u>STERLING CEMETERY</u> | | <u>STERLING, VIRGINIA</u> | | | |
| 24. FUNERAL DIRECTOR | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <u>J.B. Green - Green Funeral Home</u> | | <u>Hamden, VA.</u> | | <u>JUL - 2 1968</u> | | <u>Charles Judge</u> | | | |

52

251

THE UNIVERSITY OF CHICAGO PRESS

100

• 1990-1991, 1992-1993, 1994-1995, 1996-1997, 1998-1999, 2000-2001, 2002-2003, 2004-2005, 2006-2007, 2008-2009, 2010-2011, 2012-2013, 2014-2015, 2016-2017, 2018-2019, 2020-2021, 2022-2023, 2024-2025, 2026-2027, 2028-2029, 2030-2031, 2032-2033, 2034-2035, 2036-2037, 2038-2039, 2040-2041, 2042-2043, 2044-2045, 2046-2047, 2048-2049, 2050-2051, 2052-2053, 2054-2055, 2056-2057, 2058-2059, 2060-2061, 2062-2063, 2064-2065, 2066-2067, 2068-2069, 2070-2071, 2072-2073, 2074-2075, 2076-2077, 2078-2079, 2080-2081, 2082-2083, 2084-2085, 2086-2087, 2088-2089, 2090-2091, 2092-2093, 2094-2095, 2096-2097, 2098-2099, 2100-2101, 2102-2103, 2104-2105, 2106-2107, 2108-2109, 2110-2111, 2112-2113, 2114-2115, 2116-2117, 2118-2119, 2120-2121, 2122-2123, 2124-2125, 2126-2127, 2128-2129, 2130-2131, 2132-2133, 2134-2135, 2136-2137, 2138-2139, 2140-2141, 2142-2143, 2144-2145, 2146-2147, 2148-2149, 2150-2151, 2152-2153, 2154-2155, 2156-2157, 2158-2159, 2160-2161, 2162-2163, 2164-2165, 2166-2167, 2168-2169, 2170-2171, 2172-2173, 2174-2175, 2176-2177, 2178-2179, 2180-2181, 2182-2183, 2184-2185, 2186-2187, 2188-2189, 2190-2191, 2192-2193, 2194-2195, 2196-2197, 2198-2199, 2200-2201, 2202-2203, 2204-2205, 2206-2207, 2208-2209, 2210-2211, 2212-2213, 2214-2215, 2216-2217, 2218-2219, 2220-2221, 2222-2223, 2224-2225, 2226-2227, 2228-2229, 2230-2231, 2232-2233, 2234-2235, 2236-2237, 2238-2239, 2240-2241, 2242-2243, 2244-2245, 2246-2247, 2248-2249, 2250-2251, 2252-2253, 2254-2255, 2256-2257, 2258-2259, 2260-2261, 2262-2263, 2264-2265, 2266-2267, 2268-2269, 2270-2271, 2272-2273, 2274-2275, 2276-2277, 2278-2279, 2280-2281, 2282-2283, 2284-2285, 2286-2287, 2288-2289, 2290-2291, 2292-2293, 2294-2295, 2296-2297, 2298-2299, 2300-2301, 2302-2303, 2304-2305, 2306-2307, 2308-2309, 2310-2311, 2312-2313, 2314-2315, 2316-2317, 2318-2319, 2320-2321, 2322-2323, 2324-2325, 2326-2327, 2328-2329, 2330-2331, 2332-2333, 2334-2335, 2336-2337, 2338-2339, 2340-2341, 2342-2343, 2344-2345, 2346-2347, 2348-2349, 2350-2351, 2352-2353, 2354-2355, 2356-2357, 2358-2359, 2360-2361, 2362-2363, 2364-2365, 2366-2367, 2368-2369, 2370-2371, 2372-2373, 2374-2375, 2376-2377, 2378-2379, 2380-2381, 2382-2383, 2384-2385, 2386-2387, 2388-2389, 2390-2391, 2392-2393, 2394-2395, 2396-2397, 2398-2399, 2400-2401, 2402-2403, 2404-2405, 2406-2407, 2408-2409, 2410-2411, 2412-2413, 2414-2415, 2416-2417, 2418-2419, 2420-2421, 2422-2423, 2424-2425, 2426-2427, 2428-2429, 2430-2431, 2432-2433, 2434-2435, 2436-2437, 2438-2439, 2440-2441, 2442-2443, 2444-2445, 2446-2447, 2448-2449, 2450-2451, 2452-2453, 2454-2455, 2456-2457, 2458-2459, 2460-2461, 2462-2463, 2464-2465, 2466-2467, 2468-2469, 2470-2471, 2472-2473, 2474-2475, 2476-2477, 2478-2479, 2480-2481, 2482-2483, 2484-2485, 2486-2487, 2488-2489, 2490-2491, 2492-2493, 2494-2495, 2496-2497, 2498-2499, 2500-2501, 2502-2503, 2504-2505, 2506-2507, 2508-2509, 2510-2511, 2512-2513, 2514-2515, 2516-2517, 2518-2519, 2520-2521, 2522-2523, 2524-2525, 2526-2527, 2528-2529, 2530-2531, 2532-2533, 2534-2535, 2536-2537, 2538-2539, 2540-2541, 2542-2543, 2544-2545, 2546-2547, 2548-2549, 2550-2551, 2552-2553, 2554-2555, 2556-2557, 2558-2559, 2560-2561, 2562-2563, 2564-2565, 2566-2567, 2568-2569, 2570-2571, 2572-2573, 2574-2575, 2576-2577, 2578-2579, 2580-2581, 2582-2583, 2584-2585, 2586-2587, 2588-2589, 2590-2591, 2592-2593, 2594-2595, 2596-2597, 2598-2599, 2600-2601, 2602-2603, 2604-2605, 2606-2607, 2608-2609, 2610-2611, 2612-2613, 2614-2615, 2616-2617, 2618-2619, 2620-2621, 2622-2623, 2624-2625, 2626-2627, 2628-2629, 2630-2631, 2632-2633, 2634-2635, 2636-2637, 2638-2639, 2640-2641, 2642-2643, 2644-2645, 2646-2647, 2648-2649, 2650-2651, 2652-2653, 2654-2655, 2656-2657, 2658-2659, 2660-2661, 2662-2663, 2664-2665, 2666-2667, 2668-2669, 2670-2671, 2672-2673, 2674-2675, 2676-2677, 2678-2679, 2680-2681, 2682-2683, 2684-2685, 2686-2687, 2688-2689, 2690-2691, 2692-2693, 2694-2695, 2696-2697, 2698-2699, 2700-2701, 2702-2703, 2704-2705, 2706-2707, 2708-2709, 2710-2711, 2712-2713, 2714-2715, 2716-2717, 2718-2719, 2720-2721, 2722-2723, 2724-2725, 2726-2727, 2728-2729, 2730-2731, 2732-2733,

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please reprove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|---|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|------------------------|--|--|--|--|--|--|--|--|--|------------------|--|--|--|--|--|--|--|--|--|-------|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|--|--|--|
| 09136 | | | | | | | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | 09141 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | | | | | | 2a. DATE OF DEATH | | | | | | | | | | 2b. HOUR | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| WOODROW WILSON TITUS | | | | | | | | | | June 20 1968 | | | | | | | | | | 2 PM | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. SEX | | | | | | | | | | 4. RACE | | | | | | | | | | 5. DATE OF BIRTH | | | | | | | | | | 6. AGE (In years lost birthday) | | | | | | | | | | IF UNDER 1 YEAR | | | | | | | | | | IF UNDER 24 HRS. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Male | | | | | | | | | | White | | | | | | | | | | Feb 19 1913 | | | | | | | | | | 55 YRS. | | | | | | | | | | MONTHS | | | | | | | | | | DAYS | | | | | | | | | | HOURS | | | | | | | | | | MIN. | | | | | | | | | |
| 7a. BIRTHPLACE (State or foreign country) | | | | | | | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | | | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | | | | | | 9. COUNTY OF DEATH | | | | | | | | | | Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Virginia | | | | | | | | | | USA | | | | | | | | | | | | | | | | | | | | Washington | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | | | | | | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | | | | | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | | | | | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Hagerstown | | | | | | | | | | Wash County Hospital | | | | | | | | | | Custodian | | | | | | | | | | Ferguson Co | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | | | | | | | | 13b. COUNTY | | | | | | | | | | 13c. CITY OR TOWN | | | | | | | | | | 13d. INSIDE CITY LIMITS? | | | | | | | | | | 13e. STREET AND NUMBER | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Maryland | | | | | | | | | | Washington | | | | | | | | | | Hagerstown | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | 510 Jefferson St | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | | | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| First Middle Last | | | | | | | | | | First Middle Last | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Henry L. Titus | | | | | | | | | | Mae Gant | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | | | | | | | | 16b. SOCIAL SECURITY NO. | | | | | | | | | | 17. INFORMANT | | | | | | | | | | Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| No | | | | | | | | | | --- | | | | | | | | | | 217-16-2004 | | | | | | | | | | Mrs Marie Ann Titus | | | | | | | | | | 510 Jefferson St | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | Hagerstown Md. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) | | | | | | | | | | Bronchopneumonia | | | | | | | | | | 2-3 days | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | (b) | | | | | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 485 X | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 491 X | | | | | | | | | | (c) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | Chronic alcoholism, Emphysema | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | | | | | 20a. AUTOPSY? | | | | | | | | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | | | | | | | 21b. TIME OF INJURY | | | | | | | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | HOUR A.M. Month Day Year | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| | | | | | | | | | | P.M. 19 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED | | | | | | | | | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | | | | | | | | 21f. LOCATION | | | | | | | | | | Street or R.F.D. No. City or Town County State | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 June 1968, to 20 June 1968, that (I) (we) last saw the deceased alive on 19 June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22b. SIGNATURE | | | | | | | | | | 22c. DATE SIGNED | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford | | | | | | | | | | 21 June 68 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22d. PHYSICIAN'S NAME (Type) | | | | | | | | | | 22e. ADDRESS | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Richard T. Binford, M. D. | | | | | | | | | | 1135 Potomac Avenue | | | | | | | | | | Hagerstown, Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | | | | | 23b. DATE | | | | | | | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | | | | | | | 23d. LOCATION (City or Town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Burial | | | | | | | | | | 6/24/68 | | | | | | | | | | Boonsboro Cemetery | | | | | | | | | | Boonsboro Wash Co Md. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR | | | | | | | | | | Hagerstown Md. ADDRESS | | | | | | | | | | 25a. REC'D BY REGISTRAR | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| Andrew K. Coffman | | | | | | | | | | Funeral Home Inc | | | | | | | | | | JUN 26 1968 | | | | | | | | | | Charles Judge | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

00138

June 20 1968

TITUS

WILSON

WOODSON

15

July 19 1913

White

Male

Washington

USA

Virginia

Personnel Co

Chastell

County Hospital

Hampton

10 11 12 13 14 15 16 17 18 19 20 21 22 23 24 25 26 27 28 29 30 31

Washington

Hampton

Hampton

Hampton

417-10-2000 Mrs. Titus 510 Jefferson St

Hampton

Boonshoro Wash Co Md.

Boonshoro Cemetery

0/20/68

Hampton

Hampton Funeral Home Inc

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|------------------------|--|
| 09137 | | | | | 09142 | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | | | 2a. DATE OF DEATH | | | 2b. HOUR | | |
| Earl Hanks Trueax | | | | | 6 Month 15 Day 68 Year | | | 10:50 AM | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR | | |
| male | | white | | 1-27-1893 | | 75 YRS. | | MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Penna. | | USA | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Wash. County Hospital | | | Farmer | | Farming | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Penna. | | | Fulton | | Crystal Spring | | | | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| Palmer Trueax | | | | | Irene Hanks | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Address | | | | | |
| No | | | 200-28-3231 | | Velma Trueax Crystal Spring, Penna. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Massive Pulmonary Embolism</u>
DUE TO, OR AS A CONSEQUENCE OF
(b) <u>Phlebotrombosis of Deep leg veins</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u>Congestive Heart Failure</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>4341</u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>days</u>
<u>days</u>
<u>years</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)
<u>Pneumonia, Chronic bronchitis & emphysema</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>5-24-68</u> , 19 <u>68</u> , to <u>6-15</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>6-15</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE <u>Charles C. Spencer</u> | | | | | DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED 6/18/68 | | | |
| 22d. PHYSICIAN'S NAME (Type) Charles C. Spencer, M.D. | | | | | 22e. ADDRESS 145 S. Prospect St., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, or other disposition (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | | |
| burial | | 6-18-68 | | McKendree Cemetery | | Fulton Co. Penna. | | | | |
| 24. FUNERAL DIRECTOR ADDRESS | | | | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| Minnich Funeral Home Hagerstown, Md. | | | | | DATE JUN 19 1968 | | <u>Charles Judge</u> | | | |

00137

CHURCH OF BRITAIN

00137

Washington

USA

Female

White

1-2-1923

Texas

Frank

Male

Wash. County Hospital, Warner

Warner

Fulton, Fulton, Fulton, Fulton

Fulton, Fulton, Fulton, Fulton

no 200-22-3231 Fulton, Fulton, Fulton, Fulton

6-18-24, Wakenhoe Cemetery

Fulton Co., Tenn.

Union, Union, Union, Union

1-2-1923

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | |
|--|--|--|--|--|--|---|-----------------------|---|--|--|------------------------------|---|--|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First
<i>Reilly</i> | | Middle
<i>R</i> | | Last
<i>Ulrich</i> | | 2a. DATE OF DEATH
Month Day Year
<i>June 12 1968</i> | | 2b. HOUR
<i>8:20 P.M.</i> | | |
| 3. SEX
<i>Male</i> | | | 4. RACE
<i>White</i> | | 5. DATE OF BIRTH
<i>Feb 2, 1884</i> | | | 6. AGE (In years last birthday)
<i>84</i> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS
IF UNDER 24 HRS.
HOURS MIN. | | | |
| 7a. BIRTHPLACE (State or foreign country)
<i>Lebanon, PA.</i> | | | 7b. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. COUNTY OF DEATH
<i>Washington Co.</i> | | | | |
| 10. CITY OR TOWN OF DEATH
<i>Williamsport</i> | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<i>Williamsport Sanatorium</i> | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<i>Tool Maker</i> | | | 12b. KIND OF BUSINESS OR INDUSTRY
<i>Machy. Mfg.</i> | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<i>Maryland</i> | | | 13b. COUNTY
<i>Washington</i> | | | 13c. CITY OR TOWN
<i>Hagerstown</i> | | | 13d. INSIDE CITY LIMITS?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET AND NUMBER
<i>1717 Terrace</i> | |
| 14. FATHER'S NAME
First Middle Last
<i>George Ulrich</i> | | | 15. MOTHER'S MAIDEN NAME
First Middle Last
<i>Lucinda Field</i> | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown
<i>Yes</i> | | | 16b. SOCIAL SECURITY NO.
<i>217-18-6292</i> | | | 17. INFORMANT
<i>Granddaughter - Mrs. A.M. Bacon</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Pneumonia, terminal</i>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <i>486X</i>
(b) _____
DUE TO, OR AS A CONSEQUENCE OF
(c) _____
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>ASCVD, H stroke</i>
<i>Cancer of Rectum, Cancer of Prostate, Anemia, Parkinsonism</i> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<i>1 wk</i> | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 20b. IF YES, WERE FINDINGS CONSIDERED IN DETERMINING CAUSES OF DEATH? | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>11 Jan 1961</i> , to <i>date</i> , 19 <i>1968</i> , that (I) (we) last saw the deceased alive on <i>6 June 1968</i> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE
<i>Richard T. Binford</i> | | | | | | DEGREE <i>M.D.</i> ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | | 22c. DATE SIGNED
<i>14 June, 1968</i> | | | | |
| 22d. PHYSICIAN'S NAME (Type)
<i>Richard T. Binford, M.D.</i> | | | | | | 22e. ADDRESS
<i>1135 Potomac Ave., Hagerstown, Md. 21740</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | | 23b. DATE
<i>6/15/68</i> | | | 23c. NAME OF CEMETERY OR CREMATORY
<i>Rest Haven Cemetery</i> | | | 23d. LOCATION (City or Town) (County) (State)
<i>Hagerstown-Washington-Md.</i> | | | | |
| 24. FUNERAL DIRECTOR
<i>Wm. C. Hoist</i> | | | | | | ADDRESS
<i>Rest Haven Funeral Chapel Hagerstown, Md.</i> | | | 25a. REC'D BY REGISTRAR
DATE <i>JUN 18 1968</i> | | | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE
<i>Charles Judge</i> | | | | | | | |

MEDICAL CERTIFICATION

2630

Joseph D. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers on pages 1 and 2 and file with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|--|------------------------------|--|---|---|---|---|--|---|--|
| CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First Middle Last | | | 2a. DATE OF DEATH
Month Day Year | | 2b. HOUR
M | | |
| Oliver | | | Dearmont Vincent | | | June 19 1968 | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | | |
| Male | | White | | August 30, 1912 | | 55 YRS. | | IF UNDER 24 HRS.
HOURS MIN. | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
Md. | | | | |
| Virginia | | USA | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington County Hospital | | | Cab Driver | | Transportation | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Hagerstown | | YES | | 235 N. Locust St. | |
| 14. FATHER'S NAME
First Middle Last | | | 15. MOTHER'S MAIDEN NAME
First Middle Last | | | | | | | |
| Charles Vincent | | | Mamie Hilliard | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT
Address | | | | | |
| No | | | 219-05-2639 | | Mrs. Faith Vincent 235 N. Locust St. Hagerstown, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 5719 Blood loss - Anemia 7 days
DUE TO, OR AS A CONSEQUENCE OF
(b) Esophageal varices - rupture 7 day
DUE TO, OR AS A CONSEQUENCE OF
(c) Carcinoma of liver years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
Hx. gastric ulcer. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Mar 1967, to date, 1968, that (I) (we) lost saw the deceased alive on 19 June 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE
Richard T. Binford | | | | | DEGREE
ATTENDING PHYS. | | MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
20 June, 1968 | |
| 22d. PHYSICIAN'S NAME (Type)
Richard T. Binford, M.D. | | | | | 22e. ADDRESS
1135 Potomac Ave., Hagerstown, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | | 6/22/68 | | Rest Haven Cemetery | | Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR
Wm. G. Hest | | | | | ADDRESS
Rest Haven Funeral Chapel Hagerstown, Md. | | 25a. REC'D BY REGISTRAR
DATE JUN 24 1968 | | 25b. REGISTRAR'S SIGNATURE
Charles Judge | |

00132

Class: _____ Date: 10/19/55

Topic: _____

Abstract: _____

Keywords: _____

Author: _____

Source: _____

Accession Number: _____

Notes: _____

Comments: _____

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | |
|--|---------|--|---|---|---|---|--|--|------------------------|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First Middle Last | | | 2a. DATE KNOWN
OF ESTI-
DEATH MATED | | 2b. HOUR | | |
| Keller Edison Weller | | | | | | June 10 1968 | | 2A M | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (In years last birthday) | IF UNDER 1 YEAR
MONTHS DAYS | IF UNDER 24 HRS.
HOURS MIN. | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | |
| Male | White | June 4, 1923 | 45 YRS. | | | June 10 1968 | | 2A M | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | | |
| Maryland | | U.S.A. | | | | Washington | | | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Hagerstown | | | Washington County | | | Manager | | Orchard | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | | Washington | | Big Pool | | None | | | |
| 14. FATHER'S NAME First Middle Last | | | 15. MOTHER'S MAIDEN NAME First Middle Last | | | | | | | |
| Russell Weller | | | Mary Kelley Weller | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| No | | | 220-30-9224 | | Mary A. Weller Big Pool, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral Occlusion</u>
4109 DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
(b) <u>Post-sclerotic Heart Disease</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u> | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>1 hr</u>
<u>5-10 yrs</u> | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
<u>4201</u> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| 21d. INJURY OCCURRED
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Edward W. Ditto III</u> | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | 22b. DATE SIGNED <u>6/10/68</u> | | | | |
| EXAMINER'S NAME (Type) Edward W. Ditto, III, M.D. | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | |
| | | | ADDRESS (Street, city, town, or county) <u>217 W. Washington St. Hagerstown, Maryland</u> | | | | | | | |
| 23a. BURIAL, CREMATION, <u>Burial</u> | | 23b. DATE <u>June 13, 68</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Park Head</u> | | 23d. LOCATION (City or Town) (County) (State) <u>Big Pool Wash. Md.</u> | | | | |
| 24. FUNERAL DIRECTOR <u>Edward E. Thompson</u> ADDRESS <u>Thompson Funeral Home Clear Spring, Md.</u> | | | | 25a. REC'D BY REGISTRAR <u>DATE JUN 12 1968</u> | | 25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u> | | | | |

62720

WICKLY KIMBLEY, EDWARD OF DEATH

62720

100-100000

June 10, 1921 Weller Wilson Weller

June 10, 1921 Weller Wilson Weller

Washington U.S.A. Washington

Washington County Washington County Washington

Washington Washington Washington

Weller Weller Weller

250-30-322/ Mary A. Weller Big Pool, Md.

June 17, 1921 Park Road Big Pool, Md.

Thompson General Home Clear Spring, Md. 100-100000

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | |
|--|--|--|--------------------------|---|---|--|--|--------------------------------|----------------------------|
| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | |
| CERTIFICATE OF DEATH | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) | | | First | Middle | Last | 2a. DATE OF DEATH
Month Day Year | | | 2b. HOUR |
| Edna | | | | Louise | Wilson | June 26 1968 | | | M |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (In years last birthday) | | IF UNDER 1 YEAR
MONTHS DAYS | |
| Female | | White | | December 29, 1913 | | 54 YRS. | | | |
| 7a. BIRTHPLACE (State or foreign country) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH | | Md. | |
| Hagerstown, Md. | | USA | | | | Washington | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Hagerstown | | Washington County Hospital | | Housewife | | Own Home | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER | |
| Maryland | | Washington | | Hagerstown | | | | 221 S. Mont Ualla Ave. | |
| 14. FATHER'S NAME | | | First | Middle | Last | 15. MOTHER'S MAIDEN NAME | | | First Middle Last |
| Harry | | | | Cleveland | Snook | Julia | | | Viola Ridenour |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service) | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | Address |
| No | | | 031-01-8218 | | Mr. E. J. Wilson | | | | Hagerstown, Md. |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH CAUSED BY:
IMMEDIATE CAUSE (a) <u>CONGESTIVE HEART FAILURE - PNEUMONIA</u>
4120 DUE TO, OR AS A CONSEQUENCE OF
(b) <u>HYPERTENSIVE CARDIO-VASCULAR DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <u>445X</u>
DUE TO, OR AS A CONSEQUENCE OF
(c) <u></u>
APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
<u>6 DAYS - 2 DAYS</u>
Yes. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I(a)
<u>CHRONIC ASTHMATIC BRONCHITIS</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. 19 | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.) | | | | | |
| | | | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.) | | 21f. LOCATION Street or R.F.D. No. City or Town County State | | | | | |
| | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>20 June</u> , 196 <u>5</u> , to <u>26 June</u> , 196 <u>8</u> , that (I) (we) last saw the deceased alive on <u>26 June</u> , 196 <u>8</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE
<u>Wm. N. Fender</u> M.D. DEGREE | | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>28 June 1968</u> | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Wm. N. FENDER</u> | | | | | 22e. ADDRESS
<u>218 N. Potomac St., Hagerstown, Md.</u> | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION (City or Town) (County) (State) | | | |
| Burial | | 6/29/68 | | Cedar Lawn Cemetery | | Hagerstown-Washington-Md. | | | |
| 24. FUNERAL DIRECTOR <u>Wm. C. Horst</u> | | | | | ADDRESS | | 25a. REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE |
| Rest Haven Funeral Chapel | | | | | Hagerstown, Md. | | DATE <u>JUL - 1 1968</u> | | <u>J. Charles Judge</u> |

FOR STATE HEALTH DEPT.

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| DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | | | | | | | | | | | | | | |
|---|--|-------------------------|-------------------------|--|--|---|--|---|----------------------------|--|--|--|--|--|-----------------------|--|--|
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or Print) | | | First
Michael | | | Middle
W. | | | Last
Wintermoyer | | | 2a. DATE KNOWN OF ESTI-
DEATH MATED <input checked="" type="checkbox"/> 6 15 1968 | | | 2b. HOUR
7:30 P.M. | | |
| 3. SEX
Male | | 4. RACE
White | | 5. DATE OF BIRTH
Dec. 5, 1943 | | 6. AGE (In years last birthday)
24 YRS. | | IF UNDER 1 YEAR
MONTHS 6 DAYS 10 | | IF UNDER 24 HRS.
HOURS 6 MIN. | | 2c. DATE PRONOUNCED DEAD
Month 6 Day 15 Year 1968 | | | 2d. HOUR
7:30 P.M. | | |
| 7a. BIRTHPLACE (State or foreign country)
Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY?
USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. COUNTY OF DEATH
Washington | | | | | |
| 10. CITY OR TOWN OF DEATH
Hagerstown | | | | 11. NAME OF HOSPITAL OR INSTITUTION (If nat in hospital give street address)
Washington County Hosp. | | | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
Policeman | | | | 12b. KIND OF BUSINESS OR INDUSTRY
Municipal | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
Virginia | | | | 13b. COUNTY
Fairfax | | 13c. CITY OR TOWN
Fairfax City | | 13d. INSIDE CITY LIMITS?
<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET AND NUMBER
10029 Mosby Woods Dr. | | | | | | | |
| 14. FATHER'S NAME
First Harold Middle Wintermoyer Last Wintermoyer | | | | | | 15. MOTHER'S MAIDEN NAME
First Dora Middle Angelo Last Angelo | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
(Yes, no, or unknown)
No | | | | 16b. SOCIAL SECURITY NO.
(If yes give war or dates of service) | | | | 17. INFORMANT
Sharon Crouse Wintermoyer, Paw Paw, W. Va. | | | | ADDRESS c/o Postmaster | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Skull Fracture & Brain Stem In-
8192
DUE TO, OR AS A CONSEQUENCE OF Jury and Fracture Neck
2 hr.)
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
DUE TO, OR AS A CONSEQUENCE OF _____
(c) _____ | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)
8144 | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | 21b. TIME OF INJURY Month, Day, Year
HOUR A.M. 6-15-1968 P.M. 6-15-1968 | | | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)
Motorcycle Accident - | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)
State Road | | | | 21f. LOCATION Street or R.F.D. No. Rt #9 City or Town Leopold Morgan County W. Va. State W. Va. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE
DR. E.W. DITTO, III | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> | | | | 22b. DATE SIGNED
6-15-68 | | | | | | | | | |
| EXAMINER'S NAME (Type)
217 W. WASHINGTON ST., HAGERSTOWN, MD. | | | | M.D.
DR. E.W. DITTO, III | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
BURIAL | | | | 23b. DATE
6/19/1968 | | | | 23c. NAME OF CEMETERY OR CREMATORY
Woodrow Cem. | | | | | | | | | |
| 24. FUNERAL DIRECTOR
Johnson Funeral Homes, Berkeley Springs, W. Va. | | | | ADDRESS
Johnson Funeral Homes, Berkeley Springs, W. Va. | | | | 25a. REC'D BY REGISTRAR
June 18 1968 | | | | | | | | | |
| 25b. REGISTRAR'S SIGNATURE
Michael Morgan | | | | 25c. CITY, TOWN, OR COUNTY
Paw Paw, (Morgan) W. Va. | | | | 25d. LOCATION (City or Town) (County) (State)
Paw Paw, (Morgan) W. Va. | | | | | | | | | |

02148

DR. J. L. LITTON III
217 W. WASHINGTON ST., HAGERSTOWN, MD.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and file them with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A-5 (4)
30M REV. 1-7-68

| 09143 | | | | DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 | | | | 09148 | | | |
|---|--|---|--|---|--|---|--|--|--|--|--|
| CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. DECEASED-NAME
(Type or print) First Middle Last
<u>William Wingert Wolfe</u> | | | | 2a. DATE OF DEATH
Month Day Year
<u>June 26 1968</u> | | | | 2b. HOUR
M
<u></u> | | | |
| 3. SEX
<u>Male</u> | | 4. RACE
<u>White</u> | | 5. DATE OF BIRTH
<u>July 2, 1903</u> | | 6. AGE (In years last birthday)
<u>64</u> YRS. | | IF UNDER 1 YEAR
MONTHS DAYS | | IF UNDER 24 HRS.
HOURS MIN | |
| 7a. BIRTHPLACE (State or foreign country)
<u>Funkstown, Md.</u> | | 7b. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. COUNTY OF DEATH
<u>Washington</u> Md. | | | | | |
| 10. CITY OR TOWN OF DEATH
<u>Hagerstown</u> | | 11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)
<u>Washington County Hospital</u> | | 12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)
<u>Foreman</u> | | 12b. KIND OF BUSINESS OR INDUSTRY
<u>Refg. Mfg.</u> | | | | | |
| 13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE
<u>Maryland</u> | | 13b. COUNTY
<u>Washington</u> | | 13c. CITY OR TOWN
<u>Hagerstown</u> | | 13d. INSIDE CITY LIMITS?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET AND NUMBER
<u>527 W. Wilson Blvd.</u> | | | |
| 14. FATHER'S NAME First Middle Last
<u>William David Wolfe</u> | | | | 15. MOTHER'S MAIDEN NAME First Middle Last
<u>Sadie Blanche Davis</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES?
Yes, no, or unknown <u>No</u> (If yes give war or dates of service) | | 16b. SOCIAL SECURITY NO.
<u>214-09-0325</u> | | 17. INFORMANT
<u>Mrs. Laura E. Wolfe</u> | | | | Address <u>Hagerstown, Md.</u>
<u>527 W. Wilson Blvd.</u> | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
<u>4109</u> IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>
DUE TO, OR AS A CONSEQUENCE OF
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute myocardial infarction</u>
DUE TO, OR AS A CONSEQUENCE OF (c) <u>arteriosclerotic heart disease</u>
8 days | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (o)
<u>4201</u> <u>None</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION
<u>None</u> | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED
<u>-</u> | | 20a. AUTOPSY?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
<u>-</u> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING
<input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH
(If either, notify medical examiner) | | 21b. TIME OF INJURY
HOUR A.M. Month Day Year
P.M. <u>None</u> 19 <u>19</u> | | 21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)
<u>None</u> | | | | | | | |
| 21d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)
<u>None</u> | | 21f. LOCATION Street or R.F.D. No. City or Town County State
<u>- - - - -</u> | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan</u> , 19 <u>62</u> , to <u>June 26</u> , 19 <u>68</u> , that (I) <u>(we)</u> last saw the deceased alive on <u>June 26</u> , 19 <u>68</u> , and that in (my) <u>(our)</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>(we)</u> (did) <u>(did not)</u> view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE
<u>Harold R. Tritch Jr MD</u> | | | | DEGREE
<u>MD</u> | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22c. DATE SIGNED
<u>6-26-68</u> | | | |
| 22d. PHYSICIAN'S NAME (Type)
<u>Dr. Harold R. Tritch, Jr M.D.</u> | | | | 22e. ADDRESS
<u>302 N. Potomac St. Hagerstown, Md</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 23b. DATE
<u>6/29/68</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Rest Haven Cemetery</u> | | 23d. LOCATION (City or Town) (County) (State)
<u>Hagerstown-Washington-Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR
<u>W. A. Hunt</u> | | | | ADDRESS
<u>Rest Haven Funeral Chapel Hagerstown, Md.</u> | | 25a. REC'D BY REGISTRAR
<u>JUN 28 1968</u> | | 25b. REGISTRAR'S SIGNATURE
<u>Charles Judge</u> | | | |

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